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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

JULY, 1950

No. 1

IN THIS ISSUE

Shock Therapy Comes of Age

Whitman H. McConnell

Physicians and Medicine in Early Alachua County and Gainesville, Florida

Webster Merritt

General Practitioner's Care of the Prostate

A. Fred Turner, Jr.

The Naturopaths Again

An Editorial

THE N.Y. ACADEMY
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Volume XXXVII

JULY, 1950

No. 1

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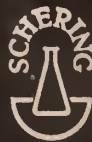
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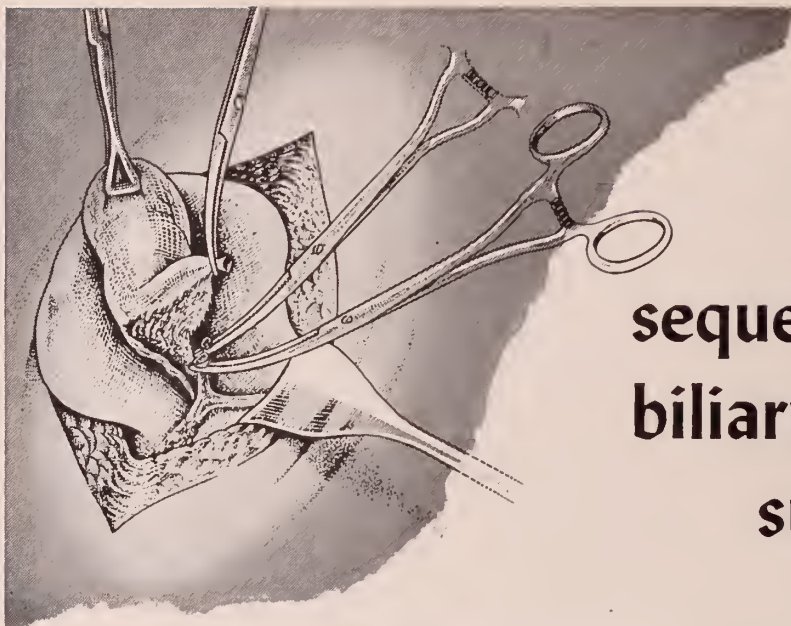
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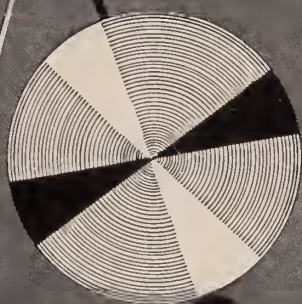
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1. Best, R. R.: Ann. Surg. 128: 348 (Sept.) 1948.

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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

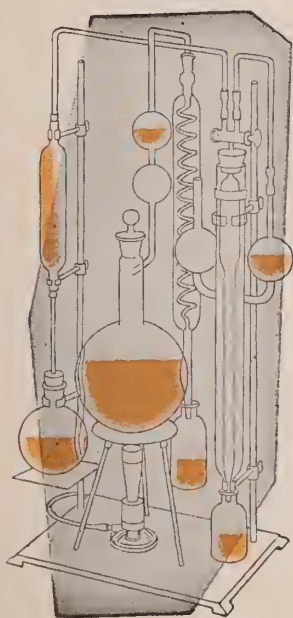


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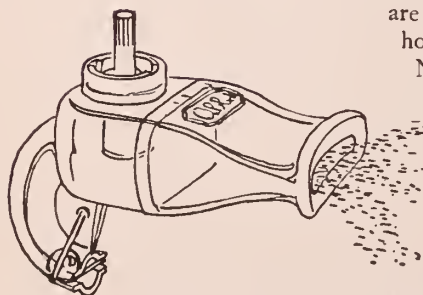
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1. Krasno, L.R., Grossman, M.I., and Ivy, A.C. (1949), The Inhalation of 1-(3',4'-Di-hydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March. 2. Krasno, L.R., Grossman, M.I., and Ivy, A.C. (1948), The Inhalation of Norisodrine Sulfate Dust, Science, 108:476, Oct. 29.

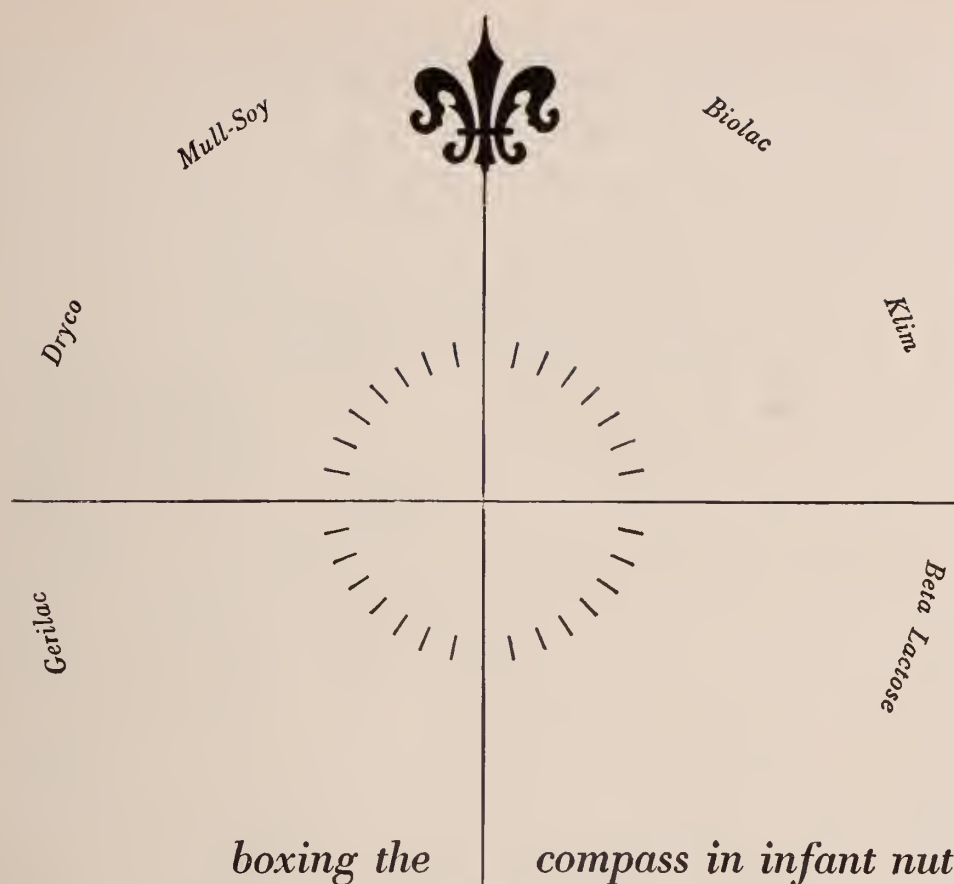
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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The Chairman of the Council, Dr. Lloyd J. Netto, has just announced that the dates of the four Medical District meetings have been officially set by the Council as follows:

Marianna, Monday, Oct. 30, 1950

Ocala, Wednesday, Nov. 1, 1950

Fort Myers, Thursday, Nov. 2, 1950

W. Palm Beach, Friday, Nov. 3, 1950

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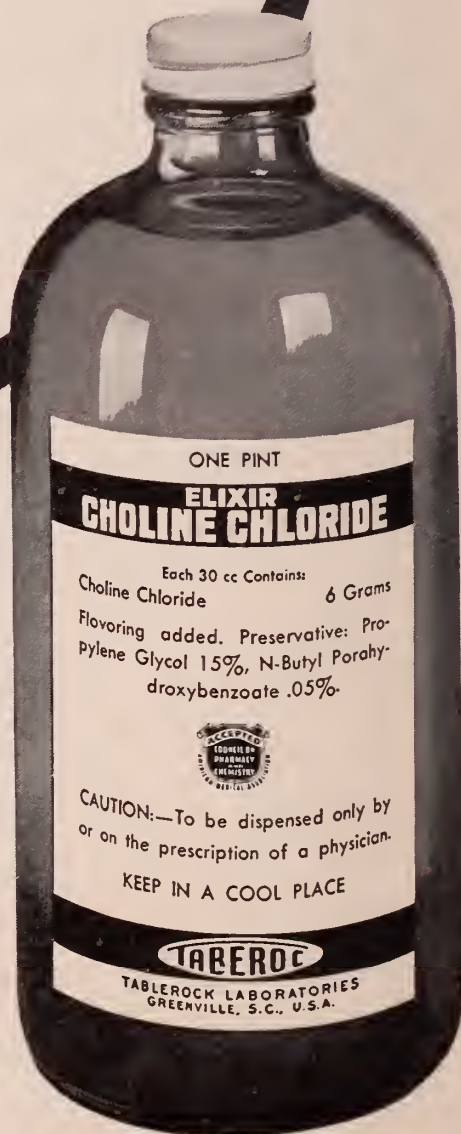
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Shock Therapy Comes Of Age

WHITMAN H. McCONNELL, M.D.

ST. PETERSBURG

In its modern version, shock therapy for the treatment of mental diseases began about 1933. It appeared to many to be a new form of treatment, but this therapy under various names, guises and forms dates back to antiquity. Treatment by flogging, humiliation, ostracism and other forms of torture associated with the casting out of devils antedated the Christian Era. In the days of the Pilgrims, psychotic women, regarded as witches, were stoned in a stock or tied in a chair to be dunked in cold water until evil influences had been driven from their bodies; failing cure, they were condemned to death or chained in a dungeon. Today, we view these old methods as ignorant, crude and torturous.

Since 1900, the numerous methods of shock therapy for the treatment of psychosis have included the use of botanic and bacteriologic agents, pharmacologic compounds, endocrines, gases, heat and applied electricity. As with any new fad, each came into being in a burst of glory with outlandish claims for its curative powers, and all were used on everything from a sore toe to a brain tumor. Many were employed by the unscrupulous practitioner for pecuniary gain. In consequence, the unrestrained use, the fantastic claims and the many abuses have tended to distract attention from the apparent beneficial effects of shock therapy in selected cases of psychosis.

Nevertheless, after wading through the mire of ignorance, intolerance and unscrupulousness, this therapy can no longer be denied its rightful place in medicine, where it can now be studied and improved upon with the passage of time. Physicians who have won a place in medical literature through their sincere efforts to alleviate the suffering of the insane patient and their contributions are:

Ray, in 1854, advocated etherization of the mentally ill.

Cheney, in 1870, used overdoses of opium in treatment.

Allbutt, in 1872, employed electricity obtained from dry cell batteries to stimulate mental activity.

Klaesi, in 1922, experimented with prolonged sleep therapy.

Bleckwenn, in 1927, tried carbon dioxide inhalations.

Sakel, in 1933, began using insulin shock as the treatment of choice. He made this important contribution accidentally after beginning in 1928 the experimental use of insulin in the treatment of drug addiction. He observed that drug addicts with a psychosis made exceptionally good progress whenever pronounced hypoglycemia developed following an overdose of insulin. Accordingly, he instituted deep insulin shock therapy in cases of acute psychosis and reported the beneficial effects that are still being observed today.

Meduna, in 1935, used camphor and then metrazol by rapid injection into the blood stream to procure an epileptiform convulsion. He reported equally good results, but noted that many patients suffered fractured vertebrae as a result of the convulsion.

Alexander, in 1938, tried nitrogen inhalations with some degree of success.

Cerletti and Bini, also in 1938, revived the use of electricity as a shocking agent and developed instruments to control the dosage and time factors.

Metrazol

Of all the methods, the three most commonly used today are, in the order of their popularity, electricity, insulin and metrazol therapy. While the results from metrazol shock therapy about equal those produced by electricity and are somewhat inferior to those obtained by the use of insulin, my associates and I stopped using this method several years ago. Its two great disadvantages are the high percentage of fractured vertebrae and broken bones due to the rapid onset and severe character of the induced convulsion and the patient's great aversion to the treatments.

When metrazol is administered, the patient lies on a hard bed with a pillow or sandbag beneath the back to minimize the possibility of fracture. Several attendants are placed at strategic points to act as pliable restrainers, and a nurse, properly trained in the use of a mouth gag, stands near the

patient's head. The physician rapidly injects through a large needle a measured quantity of metrazol into the vein and withdraws quickly to avoid traumatic complications in the ensuing convulsion, which should follow immediately. It is at this point that the morbid fear of the procedure develops. Since there is no standard dose of metrazol and death will result from an overdose, treatment must be started with the minimal dose (2 cc.). This dose is increased on succeeding days until a convulsion occurs. It was noted early that when no convulsion occurs, the patient complains of acute fear of impending death, which results in physical resistance to future treatments.

Insulin

Insulin shock therapy creates no fear in the patient, seldom causes convulsions or fractures, and gives results considered by us and many others to be far superior to all other methods. It has a further advantage in that it can be administered by a competent nurse, under medical supervision but not necessarily with the physician present at the time of the injection, thus lowering expense. The disadvantage is that it is time-consuming to the hospital and requires the constant attention of a good psychiatric nurse.

When insulin can safely be used, treatment is begun with an injection of 15 to 25 units of regular insulin, the patient's breakfast having been withheld. The dose is increased daily until there develops either a condition of subshock or deep shock, depending upon the physician's desires. This condition is maintained for from two to four hours under constant supervision; then the patient is brought out of shock by the administration of glucose.

Deaths and convulsions occur rarely. The patient, after having been brought out of shock, sometimes experiences a so-called delayed reaction in which secondary shock develops several hours later. It has been attributed to abnormal stimulation of the pancreas, and while not usually serious, it is another reason for the presence of trained personnel at all times when insulin shock therapy is administered.

Electroshock

As compared with metrazol and insulin shock therapy, electroshock is probably the most practical form of treatment, especially when working conditions are not ideal. This method is quick, relatively safe, holds no foreboding fears for the patient, requires a minimum amount of help and after-care and can be administered in a properly equipped office or in the outpatient department

of a hospital. The results equal those obtained with metrazol, and the deleterious side effects are absent. This therapy is considered specific in the treatment of involutional melancholia. While in our opinion the results do not equal those obtained with insulin, the saving in time and the far lower mortality and complication rates tend to compensate for the difference.

The treatment procedure is similar to that for metrazol therapy in that the patient lies on a padded wooden table with a support beneath the back. At least two assistants are essential. Two electrodes covered with a special conductive jelly are placed over the frontotemporal regions and are connected to the shock machine. After the machine has been set and tested, a button is pressed, and a typical grand mal epileptiform convulsion should occur, providing the time and current factors are sufficient. The convulsion usually lasts from one-half to two minutes and is followed by an interval during which the patient does not breathe and his face becomes cyanotic. This interval, to the physician waiting for that first breath, sometimes seems very long indeed. Soon afterwards, the patient regains consciousness, is confused and has a complete amnesia for the preceding events. He is returned to his room, where he usually goes to sleep for several hours. The results of the treatment are apparent upon his awakening.

Uses and Abuses

As mentioned previously, shock therapy, like the sulfonamide drugs, has been and is being abused for it is used for everything under the sun. It is a godsend for certain people and their relatives, but its use is markedly restricted to a few specific conditions, and it is useful in these mental disabilities only if the disturbance has been present for a relatively short time.

We have found by experience that the acute paranoid schizophrenia, the schizophrenia with an agitated depression, manic-depressive psychosis and involutional melancholia respond well to shock therapy providing the condition has not existed too long. It has been observed generally that the results of treatment form a geometric proportion in relation to the time interval which existed from the first apparent symptom of psychosis to the first treatment. Thus, in a case of two weeks' duration there is better than a 90 per cent chance of recovery while in a case of six months' duration the chance of recovery is about 50 per cent. In the untreated case of two years' duration, one hesitates even to guess at the possibilities of a favor-

able prognosis. With this factor in mind, it is not hard to understand why in patients with simple schizophrenia, because of its long duration, there is seldom any real or lasting improvement with shock therapy.

In general, it may be considered that all forms of psychoneurosis show no more response to shock therapy than they would to a new form of sleeping pill. At first the patient wants to believe in this "magic gadget" and apparently shows signs of improvement. With this improvement come new responsibilities, and the neurotic person again returns to his protective wall of symptoms while the shock treatment takes the same place as the old worn out sleeping pill. It is for this reason that we do not advocate shock in such cases, especially when there are better methods that are more beneficial to the psychoneurotic patient. At times, however, extenuating circumstances, usually involving a colleague, make it diplomatic to administer a series of shock treatments.

In all forms of constitutional psychopathy, shock therapy, as well as other types of treatment, is absolutely useless. It is in this field and that of the neuroses where the electric shock machine has suffered its greatest abuse. Both situations invite the activity of the unscrupulous doctor since the neurotic patient begs for any treatment not requiring effort on his part, and the psychopathic patient is usually seeking a respectable way out of some social difficulty.

The organic psychoses including the toxic, degenerative, traumatic and those arising from the avitaminoses fall into a class in which little can be expected from shock treatment. While it may serve to quiet an agitated patient, it obviously cannot repair nerve damage, remove toxins, or manufacture vitamins.

The Mechanism of Shock Therapy

The inevitable questions of how and why shock therapy works remain to be answered. Practically every psychiatrist has propounded some theory which he holds to be the answer, whether it be changes in the electric potentials, establishment of electric pathways, change in the chemical balance, or rearrangement of the endocrines. I, too, have a theory. My theory becomes simple and logical when one accepts a common standard definition of the term psychosis and in addition accepts the assumption that there are habit pathways established in the brain which become automatic with the passage of time.

Psychosis may be defined as that abnormal pattern of activity which appears in a previously nor-

mal person who has met an intolerable situation, and who has solved his problem by making a complete and successful retreat from reality whereby it becomes unnecessary to meet this intolerable situation.

That there are automatic habit pathways has been fairly well proved and is generally accepted in studies in physiology and psychology. They have been shown in numerous experiments on both animals and man. A common example is the arduous task a baby performs in learning to walk, but in time the pattern is formed on the invisible pathways of the brain, and this act of walking becomes an automatic entity. It therefore becomes evident that time is a most important factor in the formation of these habit patterns. Thus while the act of walking in an adult is within a year or so of his stated age and is automatic, it can be easily understood that if the same person is freshly out of engineering school, his act of working a slide rule has not yet had time to form so strong a habit pattern as to become automatic.

When the definition of psychosis is combined with the theory of habit pathways, it appears that an apparently normal person meets an intolerable situation and solves the problem by making a complete retreat from the world of reality, whereby a new pattern of activity is set up. It is only reasonable to assume that this new way of life begins to form habit pathways the same as did the walking or slide rule pattern of activity, and that if given sufficient time, it will form a habit pathway which is automatic and relatively unchangeable. That this contention appears to be true is shown by the psychotic patient of years' standing in whom we and others have completely failed to effect recovery regardless of the type of treatment.

In a broad sense all habits or habitual ways of acting may be classed as either good or bad, and so they are seen in the child. The child represents the early learning stages, and it is here that he begins to form those methods of solving the problems of life which carry on to adulthood. Thus it becomes of paramount importance that the parent foster the good habits and discourage the bad ones. It is common knowledge that, in a normal child, all bad habits may be changed when the child is old enough either to comprehend punishment or an intellectual lecture, providing such steps are taken before the pattern has had time to set. All too often the parent is aware of his child's errors, but for many reasons neglects to correct them, hoping that they will adjust themselves as time goes on. The child often grows up with a poor group of

habits and a poorly integrated personality with which to face life and its problems. By the same token, he is much more apt to meet an intolerable situation, which fits in with the growing contention among psychiatrists that psychosis is more of a problem of environment than of heredity. Thus it would appear that psychosis before its active inception is based upon a group of bad habit patterns gained through a poor environment, and that the final results in themselves would constitute a bad habit.

If psychosis can be labeled a bad habit pattern, it should follow that it could be changed by punishment or an intellectual lecture. Such is not the case, however, since one of the most characteristic elements of a psychosis is that reversion to earliest childhood in which there is nothing to comprehend except the organism's most selfish desires regardless of the rights of others. As the usual methods of changing this bad habit are stymied at the beginning, it becomes evident that a new approach must be established in which this chasm of noncomprehension may be bridged, and enable the normal to commune with the psychotic in terms understood by both.

As a final aid in my explanation of the how and why of shock therapy, I incorporate the phenomenon that is observed in any person who has suddenly been rendered unconscious. During the process of recovery, it has been shown that the oldest habits of action and thinking make their appearance first, followed in rapid succession by the younger habits in their proper order. It is logical then to assume that if a psychotic patient is rendered unconscious, on recovery the psychotic pattern of activity will be the last of the habit patterns to make its appearance. By the same process of logic, it is conceivable that there is an interval when the patient passes through a normal period in which normal comprehension exists, and this is a fact that may be demonstrated under proper conditions.

It becomes evident that a shock which will render the patient unconscious forms the new approach in the attempt to bridge the existing void. To be satisfactory, the shock method should not cause tissue destruction, but should be severe enough to suspend all brain activity for a short period of time. Our present forms of shock therapy are not entirely satisfactory, but they serve the main purpose, usually by a process of anoxemia of the brain.

Since the patient has been removed from his

usual environment for the purpose of treatment, there is a good possibility that he has also been removed from his intolerable situation. It is a further possibility that the attending physician may elicit this situation in that lucid moment following the treatment. With each succeeding shock treatment, this lucid interval increases as the potency of the intolerable situation decreases, and in time the doctor may be able to suggest an acceptable solution to the patient whereby he will have no further need for the psychotic pattern of activity.

Conclusion

To recapitulate, it is my contention that shock therapy is merely an agent in the re-establishment of communication whereby a normal person and normal surroundings may reach behind the dark cloak that surrounds the patient. Whether this therapy will be successful or not will depend upon how strong a habit pattern of psychotic activity has been impressed upon the invisible pathways of the brain. I further contend that shock therapy is useless in those cases of long standing because this communication cannot be re-established owing to the automatic character of the psychotic habit pattern. In other words, the psychotic way of acting has become as much a part of the patient as has his walking, and the lucid period during the recovery has diminished to a point of nonexistence. That the theory still holds is further illustrated by the failure of shock therapy in psychoneurotic and psychopathic patients, who do not need new lines of communication established. Thus it becomes increasingly clear in the application of the theory that shock therapy in itself cures nothing, but may open a door under restricted conditions whereby the true curative factors may enter.

Shock therapy has indeed come of age. It has taken its place in the field of medical treatment. Further, this therapy used in time, a matter of days not weeks, in selected cases will make useful citizens out of dangerous elements in society, and it is economically sound, as well as humane, to provide proper nursing care and adequate hospitalization facilities for these unfortunate persons.

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Physicians and Medicine in Early Alachua County and Gainesville, Florida

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Chapter I

FIRST SETTLEMENTS

The first important illness in the Alachua region, now Alachua County, was that of Hernando DeSoto in 1539, the result of a blow dealt him by the Timucuan Indian chief, Vitachuco (fig. 1). The blow was so violent he apparently did not recover his senses for half an hour. "His whole face was bruised and disfigured and several of his teeth were broken so that for 20 days he could partake of no solid food."¹ This illness appears to have occurred in an Indian village named for its chief, Vitachuco, which must have been located near a spot now known as old Wacahoota,* 10 or 12 miles west of Micanopy and a somewhat greater distance southwest of Gainesville.

The Seminoles

Toward the close of the seventeenth century, final remnants of the Timucuan Indians left Florida, but during the early eighteenth century a large group of Lower Creeks, migrating south from Georgia, united with certain Negroes from the English and Spanish colonies, thereby forming the nucleus of a new Indian nation. When the great botanist, William Bartram, visited the Alachua territory in 1774, these Florida Indians had become known as Seminoles,** a name derived from Ishti semoli, meaning wild men or wild people.⁴

Bartram wrote at length about the Alachua country, which he loved. He made no mention of human illness in the region, but he did describe a disease of cattle:

... Though the horned cattle and horses bred in these meadows are large, sleek, sprightly, and as fat as can be in general, yet they are subject to mortal diseases. I observed several of them dreadfully mortified, their thighs and haunches ulcerated, raw and bleeding, which, like a mortification of slow cancer, at length puts an end to their miserable existence. The traders and indians call this disease the water-rot or scald, and say it is occasioned by the warm waters of the Savanna, during the heats of summer and autumn when these creatures wade deep to feed on the water-grass. . . .⁵

*Fairbanks stated that the location of Vitachuco was near "Wacahoota."² This should not be confused with Wacahoota Station (New Wacahoota), which lies northwest of Micanopy and north of old Wacahoota.

**Bartram frequently referred to them as Siminoles.³

The word Alachua is said by some to have been derived from a Creek Indian word meaning grassy or marshy.⁶ It is said by others to have been derived from an Indian word meaning Big Jug, or jug without a bottom, which apparently referred to a bottomless, bowl-like lake or chasm now known as the sink (fig. 2), draining a vast expanse of marshy grassland and treeless plain,



Fig. 1. Hernando DeSoto.

formerly called the Alachua Savanna and now known as Payne's prairie.*⁷ This word is said by still others to be a derivative of the Seminole-Creek Indian word *luchuwà*, meaning jug, which was originally applied by the Indians to a natural phenomenon—a large deep chasm in the earth located somewhat to the north of the present site of Gainesville and now popularly known as the Devil's Mill Hopper.⁸ It should be noted, however, that the word Alachua, the name of an In-

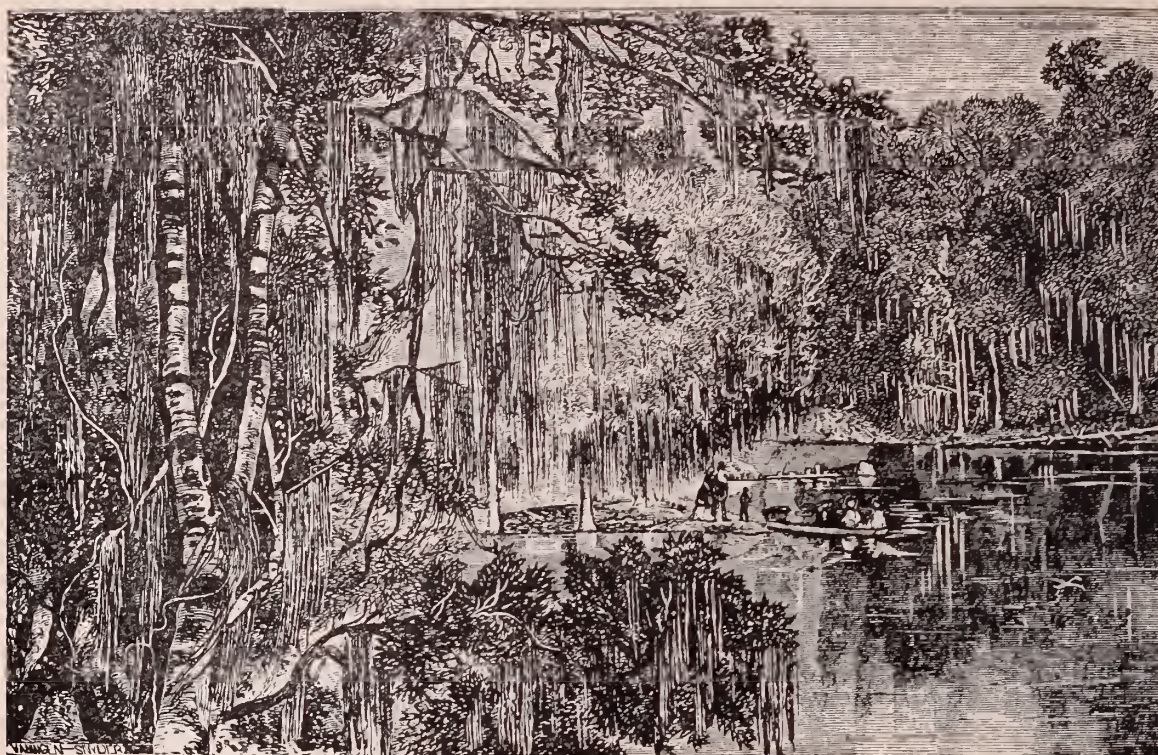


Fig. 2. The Alachua sink as it appeared in 1876.

dian village, appeared on the Herman Moll map representing the first decade of the eighteenth century, a period probably somewhat prior to the founding of the Seminole nation as such.

The Arredondo Grant

Bartram's friendly reception by the Seminole Indians in the fertile Alachua country apparently was given widespread notice. In 1817, Don Fernando de la Maza Arredondo and his son received from Spain a land grant of nearly 290,000 acres in that region, with the stipulation that they settle there 200 Spanish families, settlement to begin within three years from date,** and that they do no injury to "third persons," especially the native Indians.¹⁰ Thenceforth that tract of land was known as the Arredondo Grant. Don Fernando Arredondo, Sr., was a prominent merchant of Havana who had been of great service to Spanish authorities at the time of the invasion of the Patriot army in 1812. He had served as aide-de-camp to the Governor of St. Augustine and as comptroller of the "St. Augustine Hospital" had served without compensation, using his own fortune to protect the city when public resources failed.¹¹

¹⁰In the eighteen-eighties the subterranean passage from the "bottomless sink" apparently became obstructed, causing Payne's prairie to fill with water and to become a lake. In 1885 a small steamer was reported to be doing a good business on that sizable body of water.⁶

¹¹Later the time was extended to four years.

The first permanent settlement by white people in the Alachua region was begun by Horatio S. Dexter and Edward M. Wanton, agents for Don Fernando Arredondo. Mr. Dexter maintained his residence at Volusia, but Mr. Wanton arrived in the Alachua region on April 16, 1821. Apparently he established his home on almost the exact site of the Indian village named Cuscowilla, which was later known as Paines Town.¹² During the summer of that year, by advertising in a St. Augustine newspaper, Mr. Dexter informed travelers into "Alochawa" that they could get accommodations at "Miconopy" on the northwest bank of "Taskawilla Lake," 40 miles west of "Buena Vista," and promised them that after July 20, navigation for boats would be opened "to within 5 miles of the place."¹³ Likewise, he informed "the people of St. Mary's" that he had just received information from Mr. Wanton in "Alochawa" that Upper Creeks, who had stolen hogs and cattle, had been pursued by Seminoles, that the loot had been recovered, that it had been left at Mr. Wanton's place, and that the owners could recover their property by proper application.¹⁴

These unusual advertisements make it appear that the Arredondo agents were eager to establish the fact that Mr. Wanton had settled in that re-

gion. Years later, claims of the Arredondo Grant were confirmed in the United States courts largely because of Mr. Wanton's permanent settlement there in 1821.*¹⁵

Appearing in a New York City newspaper in November 1822, the following advertisement stirred the imagination of a few would-be pioneers:

W A N T E D

A number of S E T T L E R S

THE Florida Association will give liberal encouragement to families of good character, such as Mechanics and Farmers, who may desire to settle on some of the best lands in East Florida, (viz. Alachua tract.) None need apply but such as can bring the best testimonials of honesty, integrity, and sobriety. Application to be made in writing to T. Gibbons, 15 Stanton Street; Dr. Brush, 73 Hudson Street, or Mr. Huntington, 91 Pine Street.¹⁷ n 12 1 w

The schooner, *Bold Commander*, sailing from New York with Alachua settlers aboard, arrived at the mouth of the St. Johns River late in the month of December. After traveling up the river beyond the newly founded town of Jacksonville, the group reached a spot near the present site of Palatka. There they built a house and began construction of a road toward the west. The settlers reportedly arrived in "Alachua" on February 12, 1823, whereupon lots were surveyed and marked for the settlers, and houses were built. Among the settlers were Samuel R. Ayers, physician, LeGrand Jarvis, surveyor of New York City, Elias Haines, agent for the Florida Association in New York, two carpenters, two blacksmiths, a shoemaker and three farmers, all of whom were brought by the Florida Association. Four others making the trip from New York were brought to Florida by Mr. Moses E. Levy.¹⁸

How much came of this settlement remains in doubt. Although interested persons in later years made strong attempts to prove that a settlement was established and maintained in accordance with the terms of the Arredondo Grant, it would appear that their statements were exaggerated considerably. Mr. Wanton's and Mr. Levy's plantations apparently absorbed those who elected to stay.

In August 1823, Mr. Levy, in attempting to validate the title to a tract of 36,000 acres which he had purchased from Arredondo and Son, maintained that there were 47 people on the settlement at that time, that 25 houses had been erected, that

three plantations had been established and that 300 acres of land were under cultivation.¹⁹ The next month, Mr. Wanton gave similar testimony and stated that the company was still supporting and encouraging the progressing settlement.²⁰

Dr. Samuel R. Ayers, however, testified at a later date that he was not satisfied with his appointment as physician to the settlement and, having heard that the Indians were hostile, he left on May 5, 1823. He stated that after his departure the Florida Association sent Dr. Kelly of Charleston to Alachua to attend to the "medical department" of the settlement.²¹ It would appear that some of the other settlers shared Dr. Ayers' dissatisfaction and likewise left the settlement.

Dr. James Kelly apparently did not agree to serve as physician for the Florida Association, nor did he find much of a settlement in Alachua. Some years later, he testified that he landed in St. Augustine in November 1822 and stayed there three months before going to Paladka (Palatka). Later he traveled west on the road "cut by Mr. Hayne for the New York Company" as far as Levy's Plantation, where the road ended. He stayed seven or eight months and frequently visited Wanton's dwelling nearby. He further testified that there were no other white people in the vicinity.²²

Wanton's and Micanopy

When Dr. W. H. Simmons of St. Augustine wrote about his travels in East Florida in 1822, he believed that the "incipient town of Micconope," because of its strategic location, would probably become the capital of Florida.*²³ Micanopy, variously spelled Micanopa, Micanope, Mickanopia, Michanope,²⁵ Miconopy,²⁶ and Micconope,²⁷ however, did not develop in accordance with expectations. As a matter of fact, it remained a completely "incipient town" and, although shown on the Tanner Map of 1823 (fig. 3), it seldom was mentioned until the next decade. Mr. Wanton's home, on the other hand, was referred to frequently and was designated as the site of public meetings held in that region during the eighteen-twenties. At his dwelling, the first court held in Alachua County** was convened in 1825; there, in the same year, the Reverend John L. Jerry, pioneer circuit rider of the Methodist Church, preached in that region for the first time;²⁹ and there also a United States post office, named Wanton's, was established on May 25, 1829. Nearly five years later, on March 3, 1834, the name of this post office was changed to Micanopy.³⁰

*Harmon Hollison, an old citizen in later years, deposed that in 1821, he visited "Paines Prairie" with the brothers James, Maxey and Simeon Dell; that they stopped for two days at Edward M. Wanton's place, two miles south of "Paines Town" and northwest of "Harris Pond;" that the Indians were hostile to white people and none but Wanton had settled there.¹⁶

During those early years, Alachua County's population grew surprisingly. The state census of 1825 credited the county with having nearly 700 people while the United States census of 1830 reported more than 2,200.³¹ Apparently a large part of the growth took place in the northern part of the county.

Dell's and Newnansville

Small towns or villages in Alachua County other than Wanton's at about that time were Dell's, Hogtown, Bowlegstown and Wacahoo-tie.³² Dell's was located in the northern part of the county on or very near the well known Bellamy Road. A United States post office was established there on January 7, 1826, with Mr. James Dell serving as the first postmaster.³⁷

On November 15, 1828, an act of the territorial Legislative Council provided that the seat

of Alachua County should be established "at a place . . . usually called and known as the court house head, eight miles southeast of the Natural Bridge on the Santafee river and on United States road known at Bellamy's Road." The act further provided that this county site should thereafter be called Newnansville.³⁸ This location apparently was almost the exact site of Dell's.

Thus, although Newnansville was born near the site of Dell's in 1828 and from that time on was frequently referred to as Newnansville, the name of the United States post office was not actually changed from Dell's to Newnansville until May 1, 1837.³⁹ A surprisingly good word picture of the town, then the county seat but now abandoned,* is that of Dr. A. Rhett Motte, a surgeon in the Seminole War. In 1837, he wrote:

. . . . About 8 miles from Newnansville, we crossed the Santa-fee river, over the natural bridge. . . . Newnansville before this war, could boast of only one block house, Yelypt a court house, and one tavern, built in the same primitive style of architecture. Now it consists of two rival hotels, a fort, shops in abundance, and dwellings alias shantees so numerous, that for several days after my arrival I could scarcely find my way through the labyrinth of streets and lanes, laid out with a pleasing disregard to all rules of uniformity.

This sudden increase of population, and consequent prosperity of this incipient city, was caused entirely by an innate dread and very rational dislike of its inhabitants to being scalped. They were mostly small farmers, who had emigrated from different States and settled in Alachua County, to plant corn, hoe potatoes, and beget . . . little white headed responsibilities. . . .

The mansions of Newnansville were certainly very unique in appearance. Each abode consisted of a shed built of slab-boards, enclosing an area about twelve feet square; and were evidently calculated for exercising the rights of hospitality; for the occupants excluded nothing, even the rains always finding ready admittance. In some sheds there were several families living huddled together, under the same roof; each occupying a corner of the room, and occasionally a fifth family in the centre. . . .⁴⁰

The First Important Physician

The first physician who practiced medicine in Alachua County for an extended period of time was Dr. George Morton Payne.⁴¹ He arrived in the Micanopy region in 1835, the year of the big freeze, and began to serve a territory which extended from Newnansville on the north to Ocala on the south. Through the years which followed, he, like other pioneer physicians, came to have many interests in addition to the practice of medicine.

2033 Riverside Avenue.

*All that remains of this historic town today is a picturesque cemetery, approximately two miles northeast of the town now known as Alachua on the road to Haynesworth.

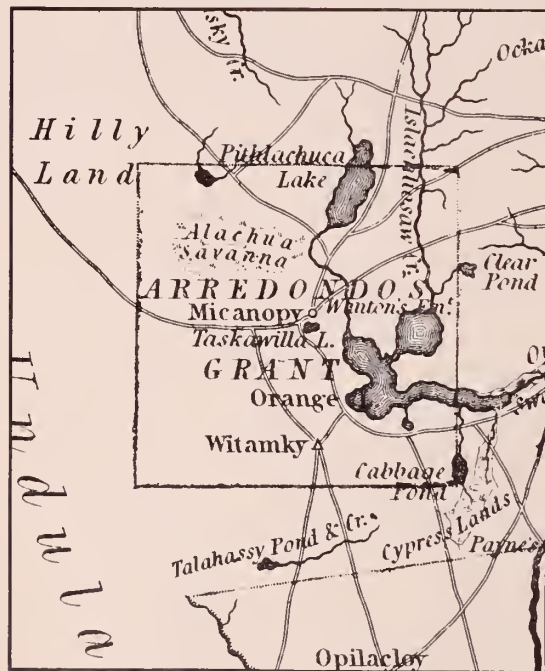


Fig. 3. From the Tanner map of 1823.

*One year later, Dr. Simmons and Mr. John Lee Williams of Pensacola met on neutral ground about midway between St. Augustine and Pensacola. After much reflection and discussion they chose the location now known as Tallahassee for the capital of Florida.²⁴

**Alachua County was created in 1824, at the meeting of the Florida legislature in Tallahassee.²⁵

***More than a century prior to that time, about 1700 to 1710, an Indian village named Alachua was located in the northern section of the Alachua region, now Columbia County.³² In 1775, the village was still shown in about the same region on the trail from St. Augustine, via Forts Picolata and Poppa, to St. Marks of Apalache.³³ It would appear that when Bartram referred to the village of Cuscowilla in 1774, he was not using the name synonymously with Alachua, but he did say that "the Indians abdicated the ancient Alachua town on the borders of the savanna . . . calling the new town Cuscowilla."³⁴ Later, some travelers apparently used the term Alachua loosely, so that it seemed they were referring to a village in that region now south of Gainesville.³⁵ An attempt to identify a town named Alachua in the region of the Alachua Savanna near Wanton's caused much confusion amongst government surveyors and attorneys during the eighteen-twenties and thirties.³⁶

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A General Practitioner's Care of the Prostate

A. FRED TURNER, JR., M.D.

ORLANDO

Acute Prostatitis

The prostate is a musculoglandular organ, normally weighing about 24 Gm. It surrounds the proximal portion of the urethra, a fact which accounts for most of its clinical importance. Hinman, in his textbooks, stated: "The frequency of prostatic involvement demands its consideration, irrespective of clinical indications, as a routine part of every physical examination." The professor of medicine during my medical school days put it somewhat more forcefully when he said: "In the complete examination of the patient, it is more important to put a finger into the rectum than a thermometer into the mouth." In the practice of urology, one cannot but be impressed with the frequency with which prostatic pathology is encountered. While no claim is made for originality in any of the statements herein made, it is hoped that some of the practical experiences obtained in the practice of urology may be of help to the general practitioner in his treatment of these prevalent disorders.

Acute prostatitis, formerly a frequent complication of gonorrheal urethritis, is somewhat unusual since the advent of penicillin. When it is encountered, the diagnosis is usually apparent. Malaise, fever, low back ache, discomfort in the perineum and rectum, vesical tenesmus, and pus and blood in the urine are some of the symptoms and signs usually pointing to the disease. On rectal examination, the prostate is swollen, hot and tender. While prostatic massage is contraindicated at this time for obvious reasons, the light pressure upon the prostate utilized in the examination of the gland often is sufficient to produce a drop of secretion which is loaded with pus. Occasionally, acute prostatitis progresses to abscess formation, and this sometimes demands surgical intervention.

The treatment of acute prostatitis has become much more satisfactory since the new chemotherapeutic and antibiotic drugs have been added to the formerly limited armamentarium of local heat, rest and sedation. Ample time must be permitted for the acuteness of the process to subside before

massage is begun. Unless the first massages are cautious and gentle, epididymitis or an exacerbation of the prostatitis may result. In judging the amount of pressure which it is safe to exert upon the prostate, the physician must not ignore the patient's complaint of pain, for the degree of tenderness offers one of the best criteria available as to the degree of compression which is safe. Prostatic massage is an uncomfortable procedure at best, but it should not be particularly painful. To carry the vigor of prostatic massage to the point of actual pain is to invite complications, regardless of the condition of the gland. The end result of acute prostatitis is usually chronic prostatitis, the treatment of which will presently be discussed.

Although instrumentation of all sorts is contraindicated in acute infections of the prostate, catheterization may become necessary if acute retention supervenes. This complication arises frequently if a prostatic abscess forms. If catheterization becomes necessary, a small (10 or 12F) indwelling, soft rubber catheter is perhaps less uncomfortable and traumatic than repeated catheterization at intervals. The best catheter to use in such circumstances is the smallest one which will permit satisfactory urinary drainage.

Chronic Prostatitis

Although acute prostatitis is becoming less frequently observed in clinical practice, chronic prostatitis is still extremely common. Chronic prostatitis may be the end result of an acute prostatitis, but more often the onset is insidious, and the history leaves the etiology and the date of onset obscure. In some cases, a history of an old supposedly uncomplicated gonorrheal urethritis, or a history of catheterization for urinary retention following an operation, suggests, but does not prove the etiology. Certain symptoms, such as a sensation of fulness or discomfort in the rectum, or of pain in the groin, spermatic cords, or low back, may lead to the examination of the prostate and the diagnosis of chronic prostatitis. Similarly, a urethral discharge or pyuria may lead to a diagnosis. Not infrequently, however, there are no symptoms, and the prostatitis is discovered when the prostatic secretion is examined as a part of the complete physical examination or during a search for foci of infection. If prostatitis is suspected, the diagnosis should not be abandoned on the strength of one negative prostatic smear. Frequently, a second examination will confirm the original diagnosis, although the first prostatic secretion examined appeared completely normal.

It is difficult to establish any arbitrary stand-

ards as to the interpretation of the prostatic smear. Most textbooks say that the finding of more than 5 leukocytes per high power microscopic field is pathologic. Proficiency in the interpretation of rectal prostatic findings and of the prostatic smear, although not difficult, increases with experience and presents no problem to the physician who does not omit this most important portion of every complete physical examination.

In many cases persistent or recurrent urethritis or pyuria which has failed to respond to oral or parenteral medication clears up promptly upon the institution of a course of prostatic massage. Often, in such cases, the use of prostatic massage is the only essential difference between the unsuccessful treatment by the general practitioner and successful treatment by the urologist to whom he eventually refers the patient. In no instance is the investigation of a case of pyuria or nonspecific prostatitis complete without adequate examination of the prostate. Even though the powerful new antibiotics now available may temporarily sterilize the urine or stop the urethral discharge, recurrence is likely unless the seeds of the process are eradicated from the prostate. The antibiotics and the chemotherapeutic drugs, unless combined with massage, usually fail to cure chronic prostatitis for the same reason that these drugs fail to sterilize encapsulated collections of pus elsewhere. The collection of pus in the acini and sometimes in the stroma of the prostate, present in prostatitis, constitute small abscesses, and as such are in no way exceptions to the surgical dictum which calls for evacuation of encapsulated pus wherever found. Superficial abscesses may be evacuated by incision and drainage. In prostatitis, however, one must resort to prostatic massage — a less complete and less satisfactory procedure than surgical incision.

The technic of prostatic massage as advocated by various physicians differs widely, but all agree that the pressure on the prostate should be made with the soft pad of the terminal phalanx of the index finger and that care should be taken not to traumatize the gland by excessive pressure or by digging the end of the finger into the gland. At the end of the procedure, the index finger is passed high into the seminal vesicle area and the seminal vesicles are stripped downward with a zigzag motion. If a specimen of prostatic secretion is not readily available after massage, pressure on the perineal urethra will usually produce a few drops of fluid. If this fails, a specimen can usually be obtained by collecting for examination the first

few cubic centimeters of the urine voided after massage.

The conventional treatment of chronic prostatitis consists of prostatic massage once or twice weekly for several weeks, with intervals of increasing length between treatments as improvement takes place. To this has been added the use of the sulfonamide and antibiotic drugs. The popularity of the former is decreasing because of the large number of adverse reactions encountered and because of the greater efficacy of some of the new antibiotic drugs. The latter are currently being evaluated, and new drugs are making their appearance from time to time. Further experience with these drugs will eventually bring order out of the currently confused situation. At present most of the reports appearing in the literature deprecate the practice of prescribing these drugs without prior complete bacteriologic investigation, but these reports usually originate in medical centers where facilities for such study not ordinarily available to the general practitioner exist. In any office, however, a gram stain of the centrifuged urinary sediment or of the prostatic secretion can be made, and this offers a rough guide in choosing the proper drug. Recent reports describe synergistic activity among the antibiotic drugs, and in some cases the use of two or more antibiotic drugs simultaneously appears to be indicated. Most of the commonly encountered bacteria are susceptible to the action of more than one drug, a fact which imposes upon the physician the necessity of choosing the one likely to be most efficacious in each particular case.

While in some cases of chronic prostatitis the response is prompt, in others the disease seems to be refractory to all treatments or tends to relapse after initial improvement. Foci of infection elsewhere in the body are thought to perpetuate the condition in some of these cases, but no cause can be found for the intractability in others. In this group of annoying cases it is often necessary for the patient and physician to accept a compromise which is somewhat short of cure. If the patient is relatively asymptomatic, too much importance should not be attached to the persistence of a few pus cells in the prostatic secretion. Such a patient should be kept under observation. An occasional prostatic massage will usually be adequate prophylaxis against any serious recurrence of the prostatitis.

Prostatism

The frequency of prostatism in advancing years makes it inevitable that the general prac-

titioner will encounter a certain number of such cases. With the passing years, there is a progressive increase in the proportion of men exhibiting hyperplasia of the prostate gland. It is estimated that 50 per cent of the men attaining the age of 80 are so affected. In only about one third of these cases are obstructive symptoms present, and the degree of obstruction is not necessarily proportional to the degree of hypertrophy.

The symptoms may consist of progressive diminution in size and force of the urinary stream, frequency, nocturia, and a feeling that the bladder is not empty after attempted voiding, or the patient may suddenly experience complete urinary retention without premonitory symptoms. The general practitioner is not likely to be wrong in his diagnosis of prostatism when there is a suggestive history in a man in the prostatic age group, but he sometimes makes the mistake of abandoning his original diagnosis upon finding a prostate which is not appreciably enlarged on rectal palpation. Rectal examination permits palpation of only a portion of the prostate gland, and considerable intraurethral and intravesical enlargement of the gland in the presence of normal rectal findings is not unusual.

To a large extent, the subsequent comfort and the eventual success of the outcome in the case of prostatism is likely to depend upon proper early handling by the general practitioner who sees the patient first. Ill advised instrumentation may lead to a variety of complications. In the diagnosis and study of a case of prostatism with clear urine, the estimation of the amount of residual urine in the bladder is not of sufficient importance to warrant the risk of infection incident to the passage of a catheter. If the urine is already infected, the principal risk involved in catheterization is the aggravation of the irritation in the prostatic urethra. The phenolsulfonphthalein test can be used in some cases to demonstrate the absence of any large amount of residual urine. The test is run in the usual manner except that fluids are limited so that the volume of each specimen, which is measured, will be small. If there is concentration of a great deal of dye in a little urine, it is obvious that the dye is not being diluted in the bladder by a large amount of residual urine.

The patient in acute retention is usually in great distress, and catheterization is an urgent necessity. First efforts at catheterization are usually made with an 18F or 20F Foley catheter in order that the catheter may be left indwelling if

successfully passed. The patient is allowed to wear the catheter and carry on with his usual activities while awaiting definitive treatment. Not infrequently, however, the Foley or the ordinary soft rubber catheter will not pass. The catheter usually passes between the enlarged lateral lobes without difficulty, but then impinges against the enlarged middle lobe which protrudes into the bladder and is held firmly against the internal vesical orifice by the increased intravesical pressure. The ordinary catheter often fails to find its way over the top of this middle lobe. This difficulty can often be overcome by the use of a curved wire mandarin within the lumen of the catheter, but this is a dangerous practice and is to be condemned except in the hands of those who have acquired special skill in urethral instrumentation. The catheter *coudé*, which has a tip with a sharp upward bend to guide it over the middle lobe, can be passed many times when other catheters fail. This catheter should be a part of the armamentarium of every physician who is likely to see such cases. The Phillips catheter, which is a woven catheter whose threaded tip fits an ordinary filiform, is another valuable instrument whose use need not be limited to the specialist.

If all efforts at catheterization fail and the bladder is palpably distended, a spinal needle may be passed into the bladder through the anterior abdominal wall just above the symphysis pubis and the urine aspirated. The danger of this procedure is minimal, for even perforation of the peritoneum or intestine is not likely to produce any consequences. A rubber tube adapter to connect needle to syringes and an assistant to steady the needle will minimize the risk of trauma. Following evacuation of its contents in this manner, the bladder will relax, and renewed efforts at inserting an indwelling catheter may now be successful. Because the next effort at catheterization may be unsuccessful, it is often unwise to remove a catheter which has been successfully passed in order to insert a supposedly more desirable one. Any catheter may be fixed in place for a while with adhesive tape.

In the presence of definite symptoms of prostatism, efforts to avoid surgery are usually futile and not without danger. Prolonged obstruction of the vesical neck eventually impairs renal function, and may lead to urinary infection, stones in the bladder, or diverticula, thus complicating an otherwise simple operative procedure.

Malignant Disease

In about one fifth of the cases of enlarged

prostate producing obstructive symptoms there is malignant disease. Unfortunately, in only a small proportion of this large group of cases of cancer is treatment sought sufficiently early to offer any hope of cure through radical surgery, which is the only hope. When carcinoma of the prostate has passed beyond the asymptomatic stage, it is almost always inoperable. Early detection in these cases must in large measure depend upon the general practitioner. The few cases encountered by the urologist in which the disease is curable are usually referred by an alert general practitioner who has noted a suspicious isolated hard nodule in the prostate on routine physical examination. Perhaps in the fight against cancer physicians may eventually educate more of the male population above 45 years of age to the importance of an annual rectal examination.

In the large group of cases of carcinoma of the prostate in which radical surgery is not feasible, treatment has been altered materially by the advent of orchiectomy and estrogens. One or more transurethral prostatic resections are usually necessary during the course of the disease. At just what time and in what order these various facilities at the disposal of the physician should be used is still a controversial matter. In advanced cases of carcinoma of the prostate not formerly treated, gratifying results will usually follow the administration of estrogens. The general practitioner may elect to carry out this part of the treatment himself, calling on the services of the urologist later when the estrogens are no longer effective, or he may turn the case over to the urologist from the start.

Tuberculosis of the prostate and prostatic calculi must be considered in the differential diagnosis of carcinoma of the prostate. Tuberculosis produces induration and nodulation of the prostate and seminal vesicles, but it usually occurs in a younger age group than carcinoma and is associated with tuberculosis elsewhere in the body, notably in the epididymis. The diagnosis of prostatic calculi is sometimes made by eliciting crepitus on rectal palpation and can be confirmed by roentgen examination. The presence of prostatic calculi must also be considered in cases in which prostatitis is refractory to treatment.

Summary

Some of the common diseases of the prostate encountered by the general practitioner are discussed, and a few suggestions are given as to their treatment.

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Multiple Small Bowel Intussusception

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During the last three years I have been privileged to observe 9 cases of intussusception of a variety not previously demonstrated on roentgenograms. Four of these cases were reported by Dr. M. D. Teitelbaum and myself¹ while at Touro Infirmary in New Orleans, and the additional 5 cases have since been detected here in Pensacola.

At this time I wish to review briefly our original paper and add the 5 additional cases together with slightly revised conclusions.

Physiology

Movements of the small intestine are under the control of intramural and extramural nervous systems, and these movements are of two types, namely, the rhythmic segmental or pendulum movements and the peristaltic contractions. The peristaltic type movements are produced by a contraction of the circular muscles of a short segment, together with a contraction of the longitudinal muscles of that same segment, producing a shortening of its length. At the same time, the intestine just distal to this constricted area is relaxed, both in diameter and length.^{2a} It becomes fairly easy to imagine the constricted, shortened segment being driven into the relaxed loop by hyperactive propulsive movements from above. In intussusception, the contracted segment is almost invariably invaginated by the distal intestine, and the intussusception increases only at the expense of the external layer. Nothnagel,³ in his famous experiment, actually produced intussusception by stimulating the intestine with a faradic current. It would appear, therefore, that intussusception can be produced by a derangement of the normal neuromuscular control of the activity of the bowel.

To continue this line of reasoning, it is logical to assume that any etiologic factor which can produce a profound neuromuscular dysfunction can produce intussusceptions. There are a number of possible agents which can produce such disordered intestinal activity. Golden^{2b} described several

cases of allergy to food in which the presence of the allergin, often milk, produced great hypermotility with hypertonic segmentation and long narrow areas in the small bowel. Fries and Zizmor⁴ found peristaltic disturbances in various parts of the gastrointestinal tract following the deliberate feeding of allergenic foods, including eggs, milk, nuts, oats, wheat and corn. In a number of cases elimination of the offending food was followed by relief of symptoms. Pansdorf⁵ described hypermotility and hyperperistalsis in hyperthyroidism. Great dilatation of loops of small bowel associated with attacks of migraine was noted by Cole and Pound.⁶ Golden^{2a} also demonstrated abnormalities of form and movement in states of early nutritional deficiency and even in profound emotional and psychic disturbances. Hodges, Rundles and Hanelin⁷ reported a series of cases in which 75 patients with demonstrable signs of altered transit time and abnormal mucosal patterns had various neurologic disorders.

The medical literature contains numerous references to intussusception. In the majority of cases it is of the ileocolic or ileocecal variety and is almost invariably a surgical emergency.⁸ The view, as presented by Bockus⁹ in giving the definition of intussusception, that "such an invagination is almost invariably associated with the phenomena of intestinal obstruction" we believe to be true of only a small group of intussusceptions. Enteric intussusceptions have also been described.¹⁰ They have been observed by pathologists at autopsy, and inasmuch as they are multiple, easily reducible, with no evidence of damage to the intestinal wall, it is concluded that they are agonal and occur immediately preceding death. Multiple intussusceptions have also been noted at operation. Baron¹¹ and Gill¹² each observed 1 case, while Close¹³ reported 3, and Baron,¹¹ reviewing the literature, listed 19 cases. The intussusceptions in these instances were in the normal direction, away from the mouth, while those of the agonal variety were retrograde.

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Furthermore, Goldman and Elman¹⁴ came to the conclusion that spontaneous reduction of intussusceptions is more frequent than commonly believed. Holt and Howland³ were of the same opinion and thought that such intussusceptions might account for some cases of severe colic in children.

The cases under discussion here are of multiple, spontaneously reducing, recurrent intussusceptions of the small intestine. In 4 cases the patients were girls between the ages of 4 and 8; in 5, boys whose ages ranged from 1½ to 7; and in 1, a man 26 years of age.

Somewhat similar histories of attacks of sudden cramping abdominal pain, often accompanied by nausea and vomiting, characterized this series of 10 cases. The attacks, of variable intensity, were transient, usually of fairly short duration, and without definite relation to food or defecation. All patients were well nourished and, except for the bouts of abdominal pain, without other evidence of disease.

Report of Cases

Case 1.—H. B., a boy aged 5. We wish to present this case although we have no roentgen demonstration of the disorder of the small bowel. The history is so similar to that in the remaining cases, and the findings at operation are so striking, that the case is included.

There was a history of intermittent attacks of abdominal pain with nausea and, rarely, vomiting. The pain was greatest in the periumbilical region and in the left upper quadrant of the abdomen. During the month prior to operation symptoms were most pronounced immediately after meals. No relief was obtained by defecation, and there was no history of constipation, diarrhea or bloody stools, nor was there significant loss of weight.

Physical examination gave negative results except for slight tenderness on deep palpation to the left of the umbilicus. Gastric analysis, urinalysis and examination of the stools and of the blood all gave normal results. The preoperative impression was possible Meckel's diverticulum.

At operation, performed by Dr. J. D. Rives, the jejunum exhibited hyperperistalsis, and three or four short segmental intussusceptions were visible when the abdomen was opened. These were reduced without difficulty, but others developed. No changes were visible in the intestinal wall, and careful palpation revealed no evidence of tumor of the small intestine. Mesenteric lymphadenitis of minor degree was present, and one node was removed for biopsy. The ileum was normal, and no Meckel's diverticulum was found.

The internist considered the possibility of intestinal allergy as an etiologic factor. Elimination of milk from the diet immediately relieved the symptoms which had not recurred in the seventeen month interval to the time of writing the original paper.

Case 2.—C. H., a girl aged 8, was examined twice within a few days and then again after an interval of approximately six months. For several months prior to the first examination she complained of periumbilical pain occurring three or four times daily. The pain increased in frequency to four or five attacks a day. There was no association with food. When an attack occurred, the child would stop playing momentarily and would then resume her activities with no after-effect. Her appetite



Fig. 1. Case 2. —Thirty minute film showing three well defined short segmental jejunal intussusceptions.



Fig. 2. Case 2. —One hundred and twenty minute film showing three intussuscepted segments, apparently not the same loops as those involved in figure 1.



Fig. 3. Case 3.—Two short intussusceptions, one in the jejunum and one probably in the ileum, are clearly defined in this thirty minute film.

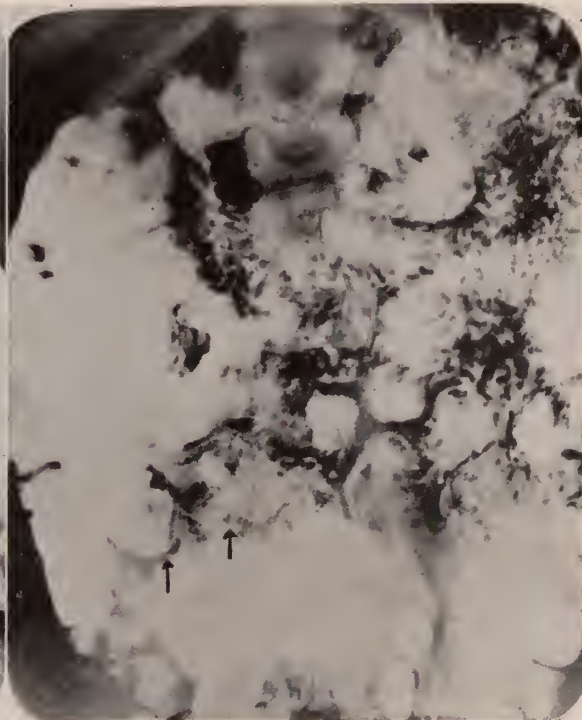


Fig. 4. Case 4.—Two short intussuscepted segments are demonstrated on this forty-five minute film.

was poor. There was no flatulence or belching, the bowels were regular, and there was no history of passage of blood from the rectum. Only slight loss of weight was noted.

The results of the first physical examination were completely negative. The second examination elicited only moderate tenderness below the umbilicus. Gastric analysis, urinalysis and examination of the stools gave negative results. Examination of the blood revealed slight eosinophilia (5 per cent) and mild anemia.

Roentgen examination was first made on July 1, 1946. Three well defined short segmental jejunal intussusceptions were observed on the thirty minute film (fig. 1). On the one hundred and twenty minute film three intussuscepted segments were visible, apparently not the same loops that were involved when the thirty minute film was made (fig. 2). On the second examination two days later, no demonstrable intussusceptions were present. The third examination was made on Nov. 10, 1947. Segmentation and clumping of the contrast material and intussusception were again seen.

The symptoms were relieved by the administration of the antispasmodics, phenobarbital and atropin, and the antihistaminic drug, elixir benadryl. The eosinophilia suggests that the symptoms may have had an allergic background and that the administration of benadryl was the significant therapeutic measure.

Case 3.—S. L., a girl aged 4, complained of cramping abdominal pain for two months. The pain was severe and came on in attacks which might last an hour and occur two or three times daily. No nausea or vomiting was experienced, and the pain was not related to nor affected by eating. Normal gain in weight was maintained. The bowels were regular, and there was no blood passed by rectum.

Roentgen examination alone gave significant information. The first examination was made on Nov. 17, 1947. Two short clearly defined intussusceptions, one in the jejunum and one probably in the ileum, were demonstrated on the thirty minute film (fig. 3). On Jan. 30, 1948 the second examination gave evidence of at least five jejunal

intussusceptions on the sixty minute film. Two persistent intussusceptions in the distal jejunum or proximal ileum were observed on the one hundred and twenty and one hundred and fifty minute films.

Attacks of cramping pain continued for four months after the initial visit, six months in all. In this case there was no relief by antispasmodic drugs, and no antihistaminic drugs were administered. Substitution diets to investigate a possible allergic basis were apparently ineffectual although the attacks have since subsided and have not recurred.

Case 4.—K. C., a girl aged 5, complained of severe abdominal pain, first experienced one month before she was examined. The initial attack occurred at night and was prolonged for two hours, the pain being associated with "cold sweat" and vomiting. There was a similar episode the next morning with repetition of the nocturnal attacks at intervals of two weeks. In the interim the child was asymptomatic. After two weeks the free intervals were shorter, and there were attacks during the day as well as at night. Symptoms were more severe when she was hungry. Her appetite was poor, but there was little loss of weight. The bowels were regular with no history of bleeding.

There was a history of recurrent swelling of the lips and hives one month before. Physical and laboratory examinations gave negative results.

Roentgen examination was made on May 13, 1948. Two short intussuscepted segments were noted on the forty-five minute film (fig. 4).

With administration of elixir of pyribenzamine, the symptoms have been much less severe, but the child still complains occasionally.

Case 5.—M. K., a girl aged 3, had for approximately one year experienced intermittent episodes of abdominal pain, usually in the morning although occasionally she was awakened by pain. The attacks, which at first lasted approximately one hour and later about fifteen minutes, came on with meals, but also when she was playing hard

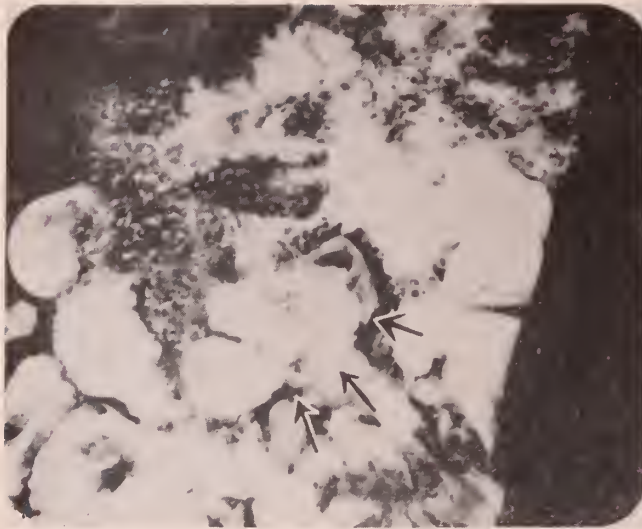


Fig. 5. Case 5.—One short enteric intussusception is visible in the lower part of the jejunum or in the proximal ileum on this thirty minute film. (above)



Fig. 6. Case 6.—A single short segmental intussusception is demonstrated in the lower portion of the jejunum on this thirty minute film. (right)

or was excited. There might be one or several daily. Nausea and vomiting occurred commonly, but not invariably. Bowel movements were frequent, with passage of undigested food particles, but no blood. Gain in weight had been steady until the onset of the symptoms, after which the patient lost 3 pounds.

Except for the roentgen study, all examinations were noncontributory. On Jan. 25, 1948 a thirty minute film gave evidence of one short enteric intussusception in the lower part of the jejunum or in the proximal ileum (fig. 5).

Urticaria developed when the patient was offered atropin and benadryl. She was given a bland diet and is much better, although one or two recurrent episodes have been experienced in the last few months.

Case 6.—A. N., a boy aged 7, had for approximately two years complained of recurrent brief attacks of fairly severe midabdominal pain, usually located above the um-

bilicus. The attacks were as a rule associated with the act of eating and were occasionally accompanied by nausea and vomiting. About two months before I saw him, the patient had contracted measles and at that time had vomited a cupful of blood. No hematemesis has since occurred, although the child's mother stated there were tarry stools for a few days following the initial episode of bleeding. The stools were otherwise normal except for mild constipation.

On March 23, 1949 roentgen examination, which alone gave contributory evidence, showed a single short segmental intussusception in the lower portion of the jejunum on the thirty minute film (fig. 6). The forty-five minute film also showed one intussusception, but whether this was a persistence of that seen on the thirty minute film or a new intussusception is not determined. There was considerable clumping and segmentation of the contrast material.

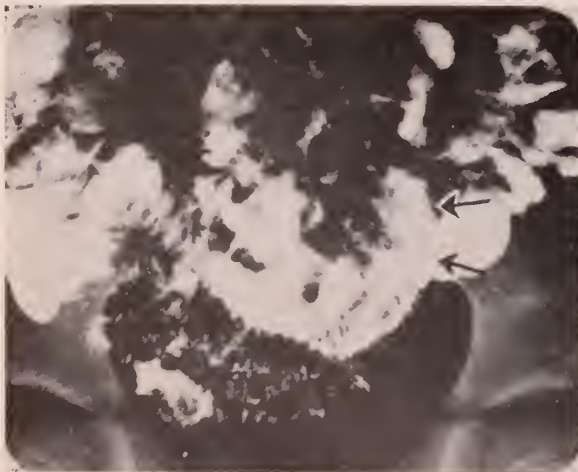


Fig. 7. Case 7.—One hundred and twenty minute film showing at least one rather long intussusception in the lower part of the ileum.



Fig. 8. Case 8.—In the lower part of the jejunum and the proximal ileum at least two telescoped segments are demonstrated on this ninety minute film, and there is evidence of disorganization of the enteric mucosal pattern.

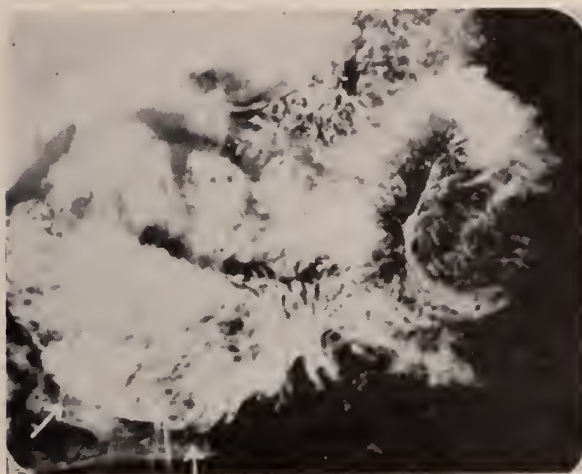


Fig. 10. Case 10.—Two proximal jejunal intussusceptions are well defined on this fifteen minute film.



Fig. 11. Case 10.—Spontaneous reduction of one of the telescoped loops shown in figure 10 is demonstrated on this film, taken a few minutes later.

Administration of ephedrine and pyribenzamine has given almost complete relief.

Case 7.—R. M., a boy aged 6, for six months had had attacks of cramping midabdominal pain usually located about the umbilicus, although on one occasion it was felt in the right lower quadrant of the abdomen. The attacks were invariably accompanied by nausea and frequently by vomiting. The vomiting was occasionally projectile in type. The episodes occurred at varying intervals, as much as a month apart, were frequently experienced at night and lasted as long as one or two days. There was apparently no relationship to food, and there was no history of bleeding by rectum. Diarrhea had occurred in the past, but not recently. The referring pediatrician stated the child was allergic to milk as a baby.

Except for the allergy, the history and physical and laboratory examinations were noncontributory. On April 21, 1949 roentgen study indicated on the one hundred and twenty minute film that at least one rather long intussusception was present in the lower portion of the ileum (fig. 7).

Considerable improvement resulted from the administration of ephedrine and pyribenzamine.

Case 8.—J. H., a boy aged 5, had for four months experienced attacks of fairly severe periumbilical pain. The attacks were sudden in onset and accompanied by belching but only occasional vomiting. No diarrhea or constipation was present, but the mother stated she had noted mucus in the stools. For three weeks the child had had an elevation of temperature to 100 F. without appreciable change in the frequency or severity of the episodes of abdominal pain. There was no apparent relationship to meals, and loss of weight was only slight.

Examination of the stools and urine gave negative results. The blood count was normal. The sedimentation rate was 33 mm. in one hour.

When roentgen examination was made on Aug. 6, 1949, at least two telescoped segments were observed in the lower part of the jejunum and the proximal ileum on the ninety minute film, together with disorganization of the enteric mucosal pattern (fig. 8). Persistence of an ileal intussusception was seen on the one hundred and twenty minute film.

Some improvement resulted from ephedrine and pyribenzamine therapy. The period of observation is, however, too short to permit drawing any definite conclusions.

Case 9.—C. B., a boy 1½ years of age, as an infant experienced vomiting of a somewhat projectile character, and a diagnosis of pyloric stenosis was therefore made. He was given goat's milk and afterward numerous formulas

were tried. The child is fussy and irritable and still vomits a good deal, but has been gaining steadily. He was referred for roentgen studies because of the episodes of vomiting and apparent colic.

The physical and laboratory examinations were noncontributory. Roentgen examination on Aug. 9, 1949 revealed one short midjejunal intussusception present on the thirty minute film (fig. 9).

Case 10.—P. E. W., a man aged 26, had episodes of cramping abdominal pain in the epigastrium which dated back at least four years. He was examined in a Veterans Hospital in 1945 and in a Naval Hospital in 1947, but no cause was found. He observed that the attacks were more frequent when the stomach was empty and appeared to be eased after meals. There was only slight loss of weight, and no nausea or vomiting occurred. He related that he was slightly constipated and that for the last four or five days the stools had been black.

The patient had been subject to epileptic seizures of a grand mal type for some time. The seizures occurred about once a month.

Laboratory examinations gave essentially negative results. When roentgen examination was made on May 2, 1949, two well defined proximal jejunal intussusceptions were demonstrated on the fifteen minute film (fig. 10). Spontaneous reduction of one telescoped loop was indicated on the roentgenogram taken a few minutes later (fig. 11).



Fig. 9. Case 9.—Thirty minute film showing one short midjejunal intussusception.

Following the roentgen examination, the patient was given antihistamines for a short time, but therapy was switched to dilantin in view of the history of epilepsy. There have been no abdominal complaints since the institution of dilantin therapy.

Discussion

In intussusception, strangulation may occur due to interference with the blood supply to the involved segment of the intestine as well as to mechanical obstruction of the bowel. If the intussusception affects only a short segment, however, and persists for only a short period of time, neither of these changes may occur. We believe, moreover, that the transient, multiple variety, in which no demonstrable change takes place in the intestinal wall, occurs far more frequently than the surgical type; it is, in fact, apparently common and has not been recognized. After observing the original 4 cases, including that of the child operated upon, Dr. Teitelbaum and I were somewhat of the opinion that the findings indicated an intestinal allergy. Indeed, it is still thought that at least in some cases such a manifestation occurs, but we now believe that this type of peristaltic disorder is merely a nonspecific symptom and may be related to such apparently unassociated diseases as epilepsy. Much careful observation of a large number of cases will be necessary before any more definite conclusions can be drawn.

Summary and Conclusions

Nine cases of multiple, transient intussusception of the small intestine are presented with radiographic demonstrations.

Transient intussusceptions of the small bowel are apparently fairly common, especially in chil-

dren, produce no permanent changes in the intestinal wall, and are a manifestation of a profound neuromuscular dysfunction.

Any etiologic factor capable of inducing a disorder of the neuromuscular coordination of the bowel can, presumably, produce this type of intussusception.

I wish to express my appreciation to Drs. Joseph L. Rubel and William P. Ilixon of Pensacola for their assistance in suspecting this condition and referring their patients for studies of the small intestine.

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Sacred Heart Hospital.

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ABSTRACTS OF MEDICAL ARTICLES

COMPLEMENT FIXATION IN HUMAN SERA FOLLOWING MURINE TYPHUS. By E. R. Rickard. *Proc. Soc. Exper. Biol. & Med.* 69:31-34, 1948.

This report describes the results of complement fixation tests performed upon the serums of 404 persons whose cases were investigated during a recent statewide survey of murine typhus in Florida. These tests were performed upon the serums of 203 persons who, it is highly probable, had suffered an attack of murine typhus seven days to three years and eleven months previously. The tests were positive in 85 to 88 per cent of the cases, and in most instances the positive titers were high. Among 201 persons suspected of having had typhus, though the diagnosis was not conclusively established, the per cent of positive reactions was less, but the titers of positive serums did not differ significantly from those of the group in which the diagnosis was considered to be established. Up to periods of four years after infection, mean positive titers at yearly intervals did not suggest a pronounced loss of titer with passage of time. With the exception of infrequent reactions at 1:2 dilutions in the serums of persons who had not had typhus, the test was found to be specific.

ON THE OCCURRENCE OF HERPES ZOSTER IN CARCINOMA OF THE BREAST. By Eugene P. Pen-dergrass, M.D., and David Kirsh, M.D. *Am. J. M. Sc.* 217:674-680 (June) 1949.

In a survey of 406 cases of carcinoma of the breast the authors noted that herpes zoster occurred in 16, giving an incidence of 4 per cent. In metastatic disease, the incidence was 11 cases in 218, or 5 per cent; in nonmetastatic disease it was 4 cases in 132, or 3 per cent. Most of the patients in whom herpes zoster developed were subjected to x-radiation, but the etiologic significance of radiation and metastases was not apparent.

The meager pathologic data in the literature appeared to indicate that metastatic disease merely prepares the soil for the invasion of the virus or causative agent of herpes zoster, rather than actually causing the disease itself. Although diagnosis is rarely a problem in carcinoma of the breast, an outbreak of herpes zoster may occasionally be a harbinger of a cryptic neoplasm or of unsuspected leukemia.

In view of the relatively high incidence of herpes zoster in carcinoma of the breast, especially in those cases in which metastasis occurs, it is suggested that all patients with this disease be subjected to a careful clinical study for possible neoplastic disease. It is observed that too often the lesions of herpes zoster are noted merely in passing, with no attention directed to the dermatomes involved and possible relationship to underlying neoplastic or inflammatory process.

CLINICAL USE OF HEPARIN AND DICUMAROL: METHODS AND PRECAUTIONS. By E. Sterling Nichol, M.D. *New Orleans M. & S. J.* 102:208-216 (Nov.) 1949.

Methods of the use of both heparin and dicumarol are discussed, and the incidence of hemorrhage and deaths from hemorrhage is emphasized. The indications and contraindications for anticoagulant therapy are summarized, as are also the disadvantages of dicumarol and heparin. These various aspects of the subject are conveniently outlined in tables. The strict necessity of meticulous care in the use of anticoagulants is stressed.

NEUROSURGICAL PROCEDURES FOR THE RELIEF OF INTRACTABLE PAIN. By W. Tracy Haverfield, M.D., and Christian Keedy, M.D. *South. M. J.* 42:1076-1078 (Dec.) 1949.

In this discussion the surgical procedures designed to alleviate the suffering of patients with intractable pain are divided into two groups: (1) those that interrupt the nerve pathways for pain, including interruption of nerves distal to their ganglia, interruption of the sensory roots of nerves, and section of the pain tracts in the spinal cord or brain; and (2) those that interrupt nerve pathways which modify the patient's reaction pattern to pain. Under the first group, peripheral neurectomy, posterior rhizotomy and spinothalamic tractotomy are discussed. Under the second group bilateral lobotomy, unilateral prefrontal lobotomy, frontal topectomy and thalamotomy are mentioned, but only bilateral prefrontal lobotomy is discussed as the other procedures remain in the experimental stage.

EMERGENCY THYROIDECTOMY, A CASE OF INTRACAPSULAR HEMORRHAGE IN AN INTRATHORACIC GOITER. By Duncan McEwan, M.D., F.A.C.S., and Robert E. Zellner, M.D. South. Surgeon 15:489-492 (July) 1949.

The authors report a case illustrating the danger of hemorrhage into an intrathoracic goiter and the necessity for emergency thyroidectomy, a relatively rare surgical procedure. In this fatal case in a 52 year old white woman, a toxic intrathoracic goiter, complicated by intracapsular hemorrhage causing pressure on the trachea, necessitated an emergency operation, which relieved the extreme respiratory embarrassment. The patient, however, succumbed because it was impossible to give adequate preoperative preparation.



THE ELECTROCARDIOGRAM IN PNEUMOPERITONEUM, INCLUDING AUGMENTED UNIPOLAR LIMB LEADS AND UNIPOLAR CHEST AND ESOPHAGEAL LEADS. By Elwyn Evans and Thomas C. Black. Am. Rev. Tuberc. 61:335-345 (March) 1950.

Electrocardiographic studies of 10 tuberculous patients receiving pneumoperitoneum therapy at the Florida State Tuberculosis Sanatorium are the basis of this paper. As a result of these studies with standard and augmented unipolar extremity electrocardiograms, numerous unipolar chest leads and esophageal leads, and with anteroposterior and lateral roentgenograms, it was observed that pneumoperitoneum with or without phrenic paresis affected the form of all leads to variable degrees. The changes were not, however, always predictable.

It was noted that pneumoperitoneum may form abnormal Q waves in the standard or unipolar limb leads. Abnormally large Q waves, usually associated with abnormal T waves, were obtained in esophageal leads at ventricular levels in each of the 10 cases. The position of the heart, especially forward displacement, was a probable factor in the production of the consistently abnormal esophageal Q waves because the heart was displaced upward and forward in each case.

Assumption of the upright position generally caused an increase in the amplitude of the esophageal Q and R waves, the R more than the Q, so that the Q/R ratio was decreased. The T waves decreased in amplitude or became more deeply inverted.

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Inalienable Rights

The founding fathers in the Declaration of Independence asserted that the citizens of this land of freedom hold certain rights to be inalienable. Among these rights are "life, liberty and the pursuit of happiness."

It would seem that these three rights are well nigh inseparable. Brought into this world without our consent, we claim the right to live. And life, to be worth living, must be free to seek its own fulfillment. Who does not crave happiness? We demand it as our right and persistently pursue it with all power, the while missing all too much of it.

These inalienable rights were never more important than they are today. Nor have they ever needed to be safeguarded more than they do at the present time. Our forefathers gave to the world "the sublime example of statesmen who had found the means of casting off the tyrant State and building up the sovereign people — unleashing the energies of free men." They knew that there can be no security in a nation without freedom.

This historic experiment sets the pattern as history would repeat itself today. Human freedom — our freedom — is again at stake. New enemies have been busy much too long already in our midst rebuilding the power of the all-powerful State and constricting our freedoms. It is imperative that we call a halt — take not one more step into socialism.

We are involved in war, a social war, and we must hold the line for the American way of life. We must dismantle the tyrant State in America now. We are confronted with the necessity of

clinging as tenaciously to our inalienable rights as did our national fathers, and for our principles of action we must revert to our history, to our Constitution and to our Declaration of Independence.

The Naturopaths Again

The Herald of Health and Naturopath for April 1950, published at 1329 16th Street, N.W., Washington 6, D. C., by the Naturopathic Health Publications and edited by one "Dr. T. M. Schippell" has just come into our hands. The publication, truly a rare gem of philosophy and medicine which purports to voice the creed of naturopathy, contains articles which fairly throw the reader on his ear.

One of the profound messages in the publication is an article entitled "Zero-ism," which states in part as follows:

... The vacuum is the meeting point of the infinite and the absolute. ... The Christhood is that virgin, vacuum, zero state through which, alone, creation can take place.

Next to *becoming* the vacuum, one's self, is finding that vacuum and *overcoming* in it. The secret is to secrete one's masculine forces into it, which results in re-creation.

X marks the spot,—the Christ cross, the criss cross. Anything that crosses over from one state of being into another must pass through the crossing point, which is hypothetically zero. When water passes from liquid to vapor, it must pass the zero vacuum point. A thought projected at this moment can be manifested or re-created. ...

Examples of passing through zero are so numerous they fill many volumes. These writings are purposely vague and un-understandable, in order to hide this secret science from the profane. ...

In order to create something, one must first create nothing. Because *nothing* is being perpetually created, there will always be more to it.—LIFE BEGINS AT ZERO.

The editor attempts to show where the publication stands on "so-called" advances in our civilized life," mentioning, among others, the following:

Opposed to vaccination for smallpox because it does not prevent smallpox, merely pollutes the blood stream and weakens its power to resist ailments.

Opposed to all unnatural systems of immunization because a clean body cannot be protected by making it unclean.

Opposed to vivisection because of the inhuman torture to helpless animals, the results of which experiments have never justified a single claim of modern medicine.

Opposed to the processing of foods because such "manufacture" tends to destroy their true nutritional values.

Opposed to the pasteurization of milk because the cooking process destroys and alters much of its nutritional elements and makes it wholly unfit for human consumption.

Opposed to a monopoly of the healing arts because healing is Nature's prerogative and her work is harmed, not helped, by coal-tar drugs and the surgeon's scalpel.

Opposed to the administration of all drugs and narcotics because they are unnatural elements which the human body is not capable of assimilating.

It would seem clear that we are dealing with a cult that is dangerous and may harm unsuspecting people, as has been previously pointed out in *The Journal*, both in August 1949 and March 1948. During their early years, naturopaths contended that drugless healing was the only way. Later, when they found that their methods were not meeting with success, they followed another tack. They maintained that they had been trained to prescribe and administer drugs and in 1947 they won their case in the courts of Pinellas County on a technicality. Since that time they have enjoyed in Florida the privilege of prescribing narcotic and other potentially dangerous drugs, but they have been denied this right in most of the states of the Union.

It appears, therefore, that the policy of their national publication now is to maintain their original thesis, that drugs are not only ineffectual but harmful. Their arguments and contentions, like their methods of practice, change and shift back and forth from side to side as they follow that dark and obscure line of reasoning called obfuscation.

It can be shown that naturopaths are poorly and inadequately trained in all instances, and fraudulently trained in many. Inasmuch as practitioners of the healing art today need to be better and more thoroughly trained than ever, there should be no short cut to the practice of medicine.

Medicine's Man of the Hour

In these crucial times there is a supreme demand for sane, intelligent, truly able leadership. Last month in San Francisco that demand appears in one instance to have been fully met when Dr. Elmer Lee Henderson, eminent surgeon of Louisville, Ky., acceded to the presidency of the American Medical Association. The amazing Dr. Henderson, world leader in this new era of medicine, gives every promise of being the right man in the right place at the right time.

Some months ago, after assigning Paul de Kruif to do a profile on the next A.M.A. president, the *Reader's Digest* decided an article by Dr. Henderson was more important than one on Dr. Henderson. The article, describing what the medical profession is doing toward promoting voluntary health plans, appeared in the May issue of that magazine. Dr. Henderson was the unanimous choice for the highest office the medical profession of the United States has to offer because, de Kruif observed, "all around, he's just about everything the best doctor can be."

At home in many world capitals, Dr. Henderson recently returned from Copenhagen, where he went on World Medical Association business, preparatory to becoming president of that organization in October. As mentioned editorially in *The Journal* in August 1949, he champions sharing this country's medical knowledge with the other nations of the world as ardently as he proclaims the family doctor as the foundation stone of good medicine. It augurs well for world medical relations that this eminently qualified leader heads the two great medical organizations concurrently, as he may confidently be expected to make the most of his strategic position and unprecedented opportunity.

Truly a self-made man, rugged at 63, possessed of astounding energy and committed to an iron routine that awes his junior colleagues, this brilliant Kentuckian is described as "a dray horse for work," who has "sweated toward one goal — maximum death-fighting skill and devotion by all doctors to all patients." To *Medicine's Man of the Hour* we offer our salute.

Wanted — Men with Convictions Willing to Voice Them

Persons in all walks of life are beginning to recognize the real intent of propagandists for nationalized medicine in this country. It is becoming evident to them that physicians are fighting against encroachment of a dictatorship state which threatens to engulf other professions and business as well.

This present attack on medicine poses a national emergency far more serious than those following the repeated politically manufactured crises to which the nation has been subjected in recent years. It is, in fact, so serious that medicine must join forces with those of other professional, business and social groups, independently of political parties, if this country is not to be dragged to the level of the nations already victimized by socialistic programs. From the beginning, this attack was designed as a part of the far more serious attack on the American way of life. So astounding, however, was this broader concept that most citizens refused to believe their political leaders could be so blind to the interests of their country.

Voicing these sentiments in a recent address in Dallas, Dr. Ernest E. Irons, the retiring president of the American Medical Association, made a strong plea for "men with convictions who are willing to voice them." Prohibition is being replaced by compulsion, he declared, and what began as an innocent effort for comfort and happiness is becoming a destructive instrument of dictatorship. Many will agree with him that now is the time for every citizen to make up his mind whether he wants economic freedom or socialist slavery of the welfare state.

The socialist bait of easy living, something for nothing, everything done for the citizen by a paternalistic government and the socialist welfare state has great appeal to the uninformed and unthinking citizen, he continued. He must therefore be shown that with each government gift, for which he himself will pay, there is imposed an additional shackle on his personal freedom. For those looking to the federal government for subsidies, Dr. Irons sounded the warning that every subsidy carries with it the threat of regulation despite any disclaimer of present intent.

Freedom and easy living are no more synonymous now than in colonial days, he observed, adding that loaf and spand cannot replace work and save in the economy of a free people. There is no place now for "double talk or double dealing — no

compromise" — one cannot "compromise with the truth."

With Dr. Irons we are agreed that "we have a great cause in which we can all unite in action as well as in purpose — that of saving this country from a downfall similar to that of the European nations." Let us as men of convictions rise up and voice them in behalf of this cause.

Blood Banks Annual Meeting

The third annual meeting of the Florida Association of Blood Banks brought medical leaders from throughout the state and distant corners of the country to Ponte Vedra on May 13 for a two day session. Dr. Lucien Y. Dyrenforth, President, presided over the opening business session. The special feature of the afternoon scientific session was an address by Dr. Thomas H. Selden, President of the American Association of Blood Banks and Director of the Mayo Clinic Blood Bank, whose subject was "Study of Transfusion Reaction Rates in Certain Diseases." In comment, Dr. Dyrenforth said that this paper "reflects the highly scientific and careful work now going forward in many parts of the country to bring blood banking into wider scope as a medical tool. As modern medicine advances, whole blood and blood products will assume increasingly important roles in combatting diseases, in prolonging life, in bringing comfort and hope to many who, without this relatively new healing aid in the hands of competent medical men, would be doomed to suffering and death."

Other distinguished guest speakers and their subjects were: Dr. Cove C. Mason, Chicago, "The Chicago Blood Procurement Center;" Dr. Wayne Rundles, Hematologist, Duke University Medical School, Durham, N. C., "Advances in Knowledge Regarding the Macrocytic Anemias;" Dr. W. L. Sheppard, Professor of Clinical Pathology, University of Georgia Medical School, Augusta, Ga., "Blood Bank Problems in a University Hospital;" Dr. Walter B. Frommeyer, Jr., Instructor in Medicine, University of Alabama Medical School, Birmingham, Ala., "Blood Substitutes, Their Use and Abuse;" Dr. Marion R. Rymer, Director, Belle Bonfils Memorial Blood Bank, Denver, Col., "Rh Studies on Cases of Cerebral Palsy, Their Siblings and Parents;" and Marjorie Saunders, Administrative Assistant, William Buchanan Blood Center, Dallas, Texas. Dr. Rundles was the principal speaker at the banquet.

Election of officers, which formally closed the

convention, was followed by "open house" at the Jacksonville Blood Bank. Dr. William C. Thomas of Gainesville succeeded Dr. Dyrenforth as president. Named to serve with Dr. Thomas were Dr. Duncan T. McEwan, Orlando, President-Elect; Dr. Donald W. Smith, Miami, Vice President; Dr. James M. McClamroch, Gainesville, Secretary; Mrs. Lenox H. Rand, Orlando, Treasurer, and Mrs. Dorothy C. Smith, Jacksonville, Executive Secretary.

American College of Surgeons Approves State Board of Health Tumor Clinics

Upon the recommendation of its representative, following a recent inspection, the American College of Surgeons has approved the following State Board of Health Tumor Clinics: Diagnostic Centers—Ft. Lauderdale, Gainesville, Ocala, Orlando, St. Petersburg and West Palm Beach; Detection Centers—Daytona Beach and Miami; Cancer Clinics—Jacksonville, Miami and Tampa.

Clinics in Tallahassee and Lakeland were not visited by the representative of the American College of Surgeons inasmuch as they were just beginning to get started when he was here. Clinics that have been in operation less than a year were given a provisional approval which is customary. The clinic in Pensacola was not visited because of lack of time.

One of the requirements of the American College of Surgeons is that each tumor clinic have a minimum staff of a radiologist, pathologist, internist, surgeon and gynecologist. Diagnosis and treatment of cancer requires the knowledge of all of the specialties and it is desirable also that a tumor clinic be located in places where the other specialists, than those listed above, are practicing.

It is the intention of the State Cancer Program that where possible the patient from the small towns shall be referred back to the small hospital for surgery, or other treatment, if the patient can be taken care of in the small hospital. Each tumor clinic is operating in this method insofar as possible.

The tumor clinics are more or less autonomous. A clinic is not organized in any city until the physicians of the county medical society wish to have such a clinic organized and the physicians themselves select a director for the clinic. None of the physicians taking part in a tumor clinic is paid any salary by the State Board of Health.

Tumor clinics are financed from funds primarily appropriated by the Florida State Legislature but some financial assistance is also given by the Public Health Service and local Cancer Society.

Essay Contest

Notwithstanding a delayed decision to participate in an essay contest sponsored by the Association of American Physicians and Surgeons on the subject, "Why the Private Practice of Medicine Furnishes this Country with the Finest Medical Care," a total of 32 essays was submitted to the judges of the state level contest for their consideration.

Elimination contests were held by eight county medical societies. The three top ranking essays in each society, as determined by its own judges, were forwarded to compete with the contestants from the other county societies for prizes of \$100, \$50 and \$25, as awarded by the Board of Governors. In addition to those sent in by the county medical societies, an additional eight essays were submitted individually by contestants in counties where the local societies did not sponsor the contest.

Winners of the statewide contest were John F. Mason, Jacksonville, first prize; Marshall Megginson, Jupiter, second prize; and Orin Patton, Riviera Beach, third prize. These three essays have been submitted to the Association of American Physicians and Surgeons to compete with contestants on the national level, for six prizes ranging from \$25 to \$1,000.

Judges for the contest on the state level were Dr. William C. Thomas, Gainesville, together with Dr. James D. Glunt and Dr. C. E. Mounts of the faculty of the University of Florida.

The Committee on Public Relations is considering a similar contest to be presented to the county medical societies and boards of public instruction throughout the state in the early part of the next school year.

As this Journal goes to press, Dr. Joseph S. Stewart, Chairman of the Committee on Public Relations, has been notified that Florida's winner of second prize, Marshall Megginson of Jupiter, has won third prize in the national contest.



Dates and cities for Medical District Meetings in October—See pages 16 and 57.

YOUR BLUE SHIELD

Blue Cross Protection

"Blue Cross Protects the People — Who Protects Blue Cross?" was the subject of a recent Cincinnati address given by Dr. Paul R. Hawley, director of the American College of Surgeons and former chief executive officer of the Blue Cross and Blue Shield Commissions. Due to the extensive interest expressed in Dr. Hawley's talk, excerpts from his remarks are given below:

Blue Cross is wholly at the mercy of hospitals and doctors and must rely solely upon them for protection against abuses. It is ordinarily the doctor who says when the patient goes to the hospital, what services shall be given him while he is there and when he shall leave the hospital. The medical profession has been slow to realize that in its hands, almost exclusively, rests the success of voluntary prepayment of the costs of medical care. Voluntary health insurance can easily become too expensive for people in the low income group to afford.

The curse of cooperative enterprise is that there are always a few in the group who do their best to kill the goose that lays the golden eggs. We have them in the health professions. But no longer dare we ignore them and permit them to continue to threaten the existence of voluntary health care. We must expose them, brand them, curb them. If we delay longer in protecting ourselves from them, we shall have government medicine before we know it.

Dr. Hawley, in addition to pointing out the need for protection for Blue Cross, submitted a proposed 4-point program to accomplish that objective.

Proposed 4-Point Program

1. Education of doctors, hospitals and the public that abuses of health insurance only raise the cost of this protection, and that this cost can be kept low only by restricting its use to necessities. The education of doctors must start in the staffs of voluntary hospitals. Hospital administrators and pathologists must bring to the attention of the staff the unnecessary services that are being ordered for patients. The visiting staff must control the resident staff—and none of these measures will be effective unless they are rigidly enforced by disciplinary action.
2. Re-evaluation of hospital care, and elimination of services which are purely luxuries and do not contribute significantly to the recovery of the patients. I am most sympathetic with the problems of hospital operations, but your very existence depends on controlling the cost of hospital care.
3. Insistence upon adequate reimbursement for public services of hospitals, such as in the care of the indigent, the operation of emergency rooms and the training of doctors, nurses and technicians.
4. The development of a formula for the payment of hospitals which is fair to all concerned—to hospitals, to the Blue Cross Plan and, above all, to the Blue Cross subscriber.

RADIOLOGIST SEEKS ASSOCIATION: With Hospital, Group, or other Radiologist. Board Diplomate, Diagnosis and Therapy. Age 35. American, Cornell Graduate, healthy, hard worker. Florida license. Write 69-33, P. O. Box 1018, Jacksonville, Fla.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. John R. Browning of Jacksonville announce the birth of a son on March 27, 1950.

Dr. and Mrs. Melvin Newman of Jacksonville announce the birth of a daughter on March 25, 1950.

Marriages

Dr. Daniel R. Usdin of Jacksonville and Miss Phyllis Elaine Rosen of Miami Beach were married on May 7, 1950.

Deaths — Other Doctors

Dr. Alfonso W. Blake, Bartow (Col.) Jan. 23, 1944
 Dr. Emmett E. Brown, Nashville, Tenn. Recently
 Dr. Charles E. Filbert, Tampa Date Unknown
 Dr. George W. P. Johnson, Tampa (Col.) Sept. 10, 1949
 Dr. Francis M. Sullivan, Pompano Jan. 13, 1950

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Chardkoff, M. Austin, Tampa
 Curry, Robert W., Orlando
 Furey, Edward T., Orlando
 Grochowski, Ernest M., Sarasota
 Hammel, Joseph V., Bay Pines
 Harvey, Bennett B., Apopka
 Hooten, Claude G., Jr., Clearwater
 Kaplan, Samuel E., Venice
 Kennedy, Alpheus T., Pensacola
 Lawler, Harold T., Sarasota
 Lohrbauer, Leif T., Clearwater
 Lundquist, John R., Pensacola
 Moore, Homer J., Opa Locka
 Sinden, Richard H., St. Petersburg
 Weinkle, Isaac N., Miami
 Wing, Breckenridge W., Winter Park
 Wright, William L., Sarasota
 Yesner, Bernard, West Miami
 Young, Thomas R., Jr., Sarasota

SURGEON F.A.C.S. desires association with surgeon or group or men interested in forming a group. Board eligible, Florida license, Michigan graduate, age 42. Write 69-35, P. O. Box 1018, Jacksonville.

ASSOCIATE WANTED: Obstetrician-Gynecologist to share work in established practice, Jacksonville, Florida. Board certification not required but should have specialty training or experience. Answer by letter stating education, training and income expected. Write 69-34, P. O. Box 1018, Jacksonville, Florida.

STATE NEWS ITEMS

Drs. Frank D. Gray, Orlando, and Wilson T. Sowder, Jacksonville, attended and participated as delegates to the United States Pharmacopeial Convention in Washington, D. C., May 9-10, 1950. Drs. Gray and Sowder, together with Mr. Don S. Evans, were appointed by Dr. Walter C. Payne to serve as Florida's representatives to this convention.

One of the primary responsibilities resting upon delegates representing the various state medical associations, pharmaceutical associations, schools of medicine, schools of pharmacy and other agencies is the establishment of policy guiding the publication of *Pharmacopeia*.

Dr. Bernard J. McCloskey announces the opening of his office at 2720 Park Street, Jacksonville. Dr. McCloskey will limit his practice to internal medicine.

The Florida Obstetric and Gynecologic Society held its annual meeting at the Hollywood Beach Hotel on April 23. Dr. Emil Novak of Baltimore, Maryland, was the guest speaker. The officers for the year are: Dr. Robert T. Spicer, Miami, president; Dr. William C. Thomas, Gainesville, president-elect; and Dr. Dorothy D. Brame, Orlando, secretary-treasurer. All members of the Florida Medical Association who are doing obstetrics and who are interested in becoming a member of this society are requested to write the secretary.

Dr. Carlos P. Lamar, Miami, spoke recently to the dietitians of the Mt. Sinai Hospital on the subject of diabetes.

Dr. Graham E. Henson, Jacksonville, has been awarded a golden anniversary diploma by the Wayne University College of Medicine Alumni Association.

Dr. Lucien B. Dickerson, Clearwater, was honored recently by being included in a series of 14 Sunday biographical articles about long-time residents of the area published by the *Clearwater Sun*.

Dr. Mildred Esther Scott of the U. S. Public Health Service, has been assigned to the Florida State Board of Health, Field Technical Staff.

Dr. John A. Simmons of Arcadia was honored recently at the Arcadia General Hospital. A life-size bronze bust of Dr. Simmons was unveiled and presented to the hospital. Dr. Simmons retired from practice recently after fifty years of service to the community.

Dr. Harry F. Rolfes of Lake Wales was the speaker at the recent bi-monthly meeting of the local Women of the Moose on the subject, "The Advancement of Medicine and Medical Practice Since 1900."

Dr. Achille A. Monaco has returned to his practice in Daytona Beach following a course in surgery at the Cook County Graduate School of Medicine, Chicago. While in Chicago, Dr. Monaco also attended a convention of industrial surgeons.

Dr. Arthur H. Weiland, Coral Gables, has been appointed director of the Florida Crippled Children's Commission succeeding Dr. Leander J. Graves, Tallahassee.

Dr. R. Sam Mosley, Miami, has been appointed Florida chairman of the alumni house and faculty club project at Alabama Polytechnic Institute.

Association members who have been elected to the Board of Directors of the American Cancer Society, Florida Division, are Drs. Hugh G. Reaves, Sarasota, Vale D. Stone, West Palm Beach, George D. Lilly, Miami, Wilbur C. Sumner, Jacksonville, Maxwell M. Sayet, Miami Beach.

Dr. Lorenzo L. Parks, Jacksonville, and Frazier J. Payton, Miami, were confirmed as members of the state executive committee.

Dr. Jere W. Annis, Lakeland, spoke recently before a Winter Haven Civic Club on the subject of adequate housing for mental patients.

Dr. Samuel R. Norris, Jacksonville, has been honored by having a portion of the maternity section of St. Luke's Hospital named the "Dr. Samuel Royall Norris Wing."

Dr. Frank G. Slaughter's newest medical novel, "The Stubborn Heart," has been released for publication by Doubleday & Company.

In a setting of a war-torn colonial plantation during the re-construction period following the War Between the States, the story deals with the various problems encountered by an ex-medical officer of the Confederate army. Although not strictly a sequel to "In a Dark Garden" the story does contain the same characters and begins with the end of the war, which is the point at which the previous story ended.

The survey of physicians' incomes being conducted jointly by the United States Department of Commerce and the AMA Bureau of Medical Economic Research, is producing a gratifying response from physicians throughout the country, according to Dr. Frank G. Dickinson, Bureau Director. Dr. Dickinson advises that the return of the questionnaires by physicians exceeds that of any similar survey of other income groups.

Not all physicians were sent questionnaires. One hundred thousand were sent to doctors throughout the country, the survey being based on a scientific formula.

Dr. H. Marshall Taylor of Jacksonville attended the annual meetings of the American Laryngological Association, the American Otolological Society and the American Laryngological, Rhinological and Otological Society in San Francisco late in May. He was honored by the American Laryngological Association on May 23 when he received its James E. Newcomb Award "for contributions to laryngological literature and promoting graduate teaching in laryngology."

Dr. Charles C. Grace of St. Augustine attended the meeting of the American Laryngological, Rhinological and Otological Society in San Francisco in May. He was elected chairman of the Southern Section of that organization, which will hold its midwinter meeting in Florida in January 1951.

Dr. Raymond L. Evans has returned to his practice in Miami following a recent trip to Boston, Mass. While in Boston, he visited surgical clinics and hospitals.

Dr. Sullivan G. Bedell of Jacksonville recently addressed the West Riverside Dads' Club on the subject, "Your Child at Home and in School."

Dr. Robert B. McIver of Jacksonville has returned to his practice following an extended trip in the West. Dr. McIver attended the meetings of the Southwestern Section of the American Urological Association in Yosemite Valley and gave talks before the Surgical Society of San Diego, the Academy of Medicine in San Diego and the Hollywood, California, Academy of Medicine.

Dr. Robert F. Mikell of Miami has returned to his practice from Chicago where he attended the Michael Reese Hospital Postgraduate School.

Dr. George A. Dame, Jacksonville, was appointed general program chairman for the Southern Branch, American Public Health Association, at the recent meeting in Birmingham which he attended.

Dr. Robert E. Rothermel, formerly Associate Field Director, American Public Health Association, has assumed his duties as director of the Pinellas County Health Department with headquarters at St. Petersburg.

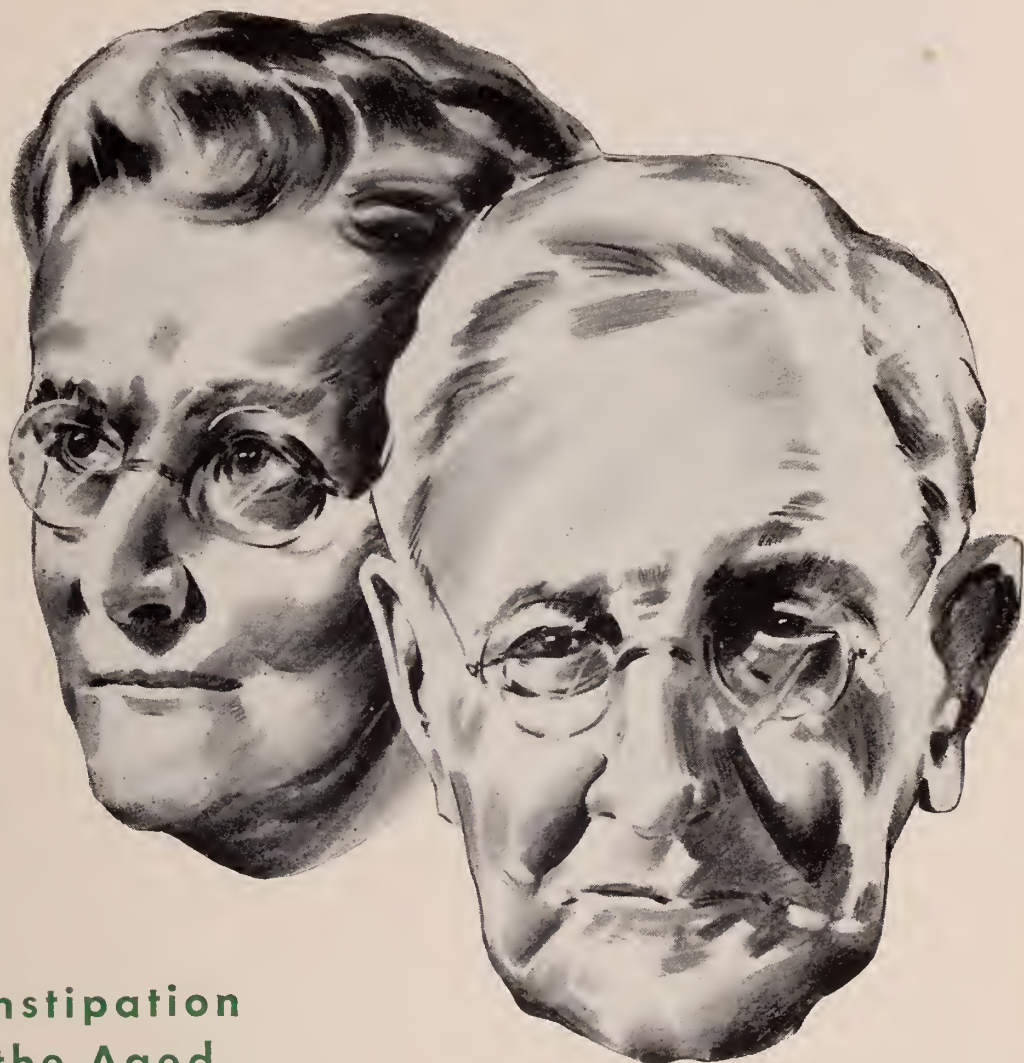
Drs. Kenneth A. Morris and Jonathan H. Wood of Jacksonville were guest speakers at a recent meeting of District 2, Florida State Nurses Association. Their subject was "Underwater or Tidal Suction."

Dr. Wade N. Stephens of Salt Lake City, Utah, assumed his duties as county health officer in Putnam and Flagler Counties on May 15. Dr. Stephens' headquarters is Palatka.

Dr. Raymond H. King of Jacksonville was elected a director of the Jacksonville Historical Society for the ensuing year.

Dr. Hugh A. Carithers of Jacksonville recently addressed the Pre-school Summer Round-up of the Annie Beaman School.

Dr. DeWitt C. Daughtry of Miami was recently elected vice president of the Florida State Tuberculosis and Health Association and State Chapter of the Trudeau Society.



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COMPONENT SOCIETY NOTES

Dade

In keeping with the role of medicine in possible future atomic warfare, Commander E. P. Cronkite (MC) of the Naval Medical Research Institute, Bethesda, Maryland, presented a paper at the Dade County Medical Association meeting, June 6, on "The Pathogenesis and Therapy of Radiation Illness Produced by the Atomic Bomb."

The discussion was led by Dr. James J. Griffiths, associate director of the Blood Bank of Dade County, who instructed his colleagues on the role that the Florida Blood Banks will play in the event of atomic warfare.

Duval

The Duval County Medical Society, at its regular monthly meeting on June 6 in the Sellers Auditorium, viewed a motion picture on the subject, "The Problem of Early Diagnosis of Breast Cancer." Dr. Samuel M. Day, Jr., presented a paper on "Management of Severe Burns."

Escambia

The Escambia County Medical Society sponsored a medical assembly on June 5. Many physicians from neighboring cities attended the meeting. The schedule of events included case presentations at Sacred Heart and Escambia General Hospitals and a tour of the School of Aviation Medicine, Naval Air Station.

Hillsborough

The Hillsborough County Medical Association has announced the establishment of a county grievance committee to be composed of five doctors and two laymen. Dr. Edward Smoak was elected as chairman of the committee and Dr. William M. Rowlett, secretary. Other members of the committee from the medical association are Drs. Chas. W. Bartlett, Edward F. Shaver and Douglas D. Martin.

(Continued on page 50)

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From where I sit
by Joe Marsh

"Curfew Shall Not Ring Tonight"

Our ten o'clock curfew lasted for over 50 years, but the town council voted it out. I dropped in at the meeting in Town Hall last week just in time to hear Smiley Roberts.

"The curfew is old-fashioned," says Smiley. "We ought to be grown-up enough by now to behave like grown-ups. Seeing to it that our kids get to bed is the responsibility of each family." Then Judge Cunningham adds, "Most of us are in bed when the curfew horn blows anyway. It wakes me up just when I'm getting to sleep!"

What the Judge said was good for a laugh, but Smiley summed up how folks think in this town. We believe that the democratic tradition of "live and let live" is the only way to live.

From where I sit, it's not the American way to regulate your life by a horn—any more than it's right to criticize my caring for a temperate glass of beer now and then. Think what you wish, say what you wish, but don't ask your neighbor to do exactly as you do!

Joe Marsh

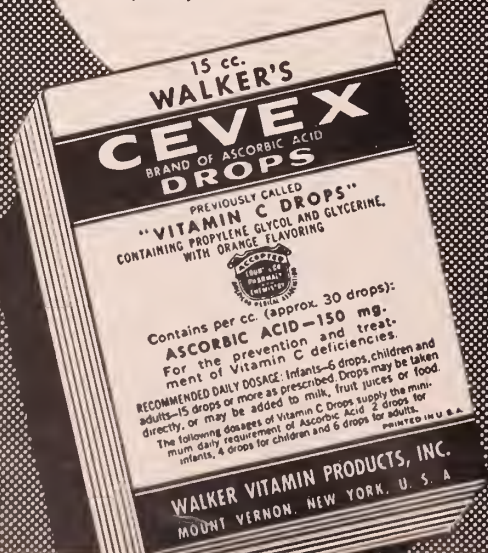
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Marion

The Marion County Medical Society has changed its meeting date from the third Wednesday of each month to the third Tuesday. At the regular May meeting, Dr. Eugene G. Peek reported to the society on the work of the Association's Legislation and Public Policy Committee. The following members were present: Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, Henry L. Harrell, John D. Lindner, Carl S. Lytle, William J. McGovern, Robbins Nettles, Eugene G. Peek, Eugene G. Peek, Jr., Robert E. Thompson and Herbert M. Webb, Jr. Dr. L. A. Brendle of Ocala, director of the Marion County Health Unit, was a guest.

St. Johns

All members of the St. Johns County Medical Society have paid their 1950 dues.

St. Lucie-Okeechobee-Martin

State dues for 1950 have been paid by all members of the St. Lucie-Okeechobee-Martin County Medical Society.

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MRS. JOHN E. MAINES, JR., Stu. Loan Fund.....*Gainesville*
MRS. NELSON A. MURRAY, Newsletter.....*Jacksonville*
MRS. RALPH S. SAPPENFIELD, Hospitality.....*Miami*

President's Message

Every medical society in the state of Florida should have an organized auxiliary behind it. We, who work in the Auxiliary, will not be content until this goal is reached. At the present time there are sixteen organized auxiliaries which means that there are twenty yet to be organized. We hope that the doctors will back us and help attain our goal of an auxiliary to each medical society. Speaking in political terms, "look at the record" and you will find that we have proven ourselves to be of inestimable value. Membership alone is not our goal but rather we would like those who are not auxiliary members to feel that they would like to be a part of a group which promotes the doctor's program of medicine and public health. Every doctor's wife in this state should know the facts concerning health conditions in her community. She should serve on committees where action is taken in bettering health conditions. The positive approach on the fight against compulsory health insurance practically compels her to be an authority on all forms of voluntary health insurance, what they give, and for how much in her particular locality. The doctor expects, and rightly so, that his wife be his top ranking agent for improved public relations. She can do this most effectively through an organized auxiliary whose main objective is to further the medical society's program for the advancement of medicine and public health.

Mrs. James L. Anderson
President

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Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting July 24, August 21, September 25. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting July 10, August 7, September 11. Personal Course in General Surgery, Two Weeks, starting September 25. Surgery of Colon & Rectum, One Week, starting September 11. Esophageal Surgery, One Week, starting October 16. Breast & Thyroid Surgery, One Week, starting October 2. Thoracic Surgery, One Week, starting October 9. Gallbladder Surgery, Ten Hours, starting October 23. Fractures & Traumatic Surgery, Two Weeks, starting October 9. Basic Principles in General Surgery, Two Weeks, starting September 11.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 25. Vaginal Approach to Pelvic Surgery, One Week, starting September 18.

OBSTETRICS—Intensive Course, Two Weeks, starting September 11.

MEDICINE—Intensive General Course, Two Weeks, starting October 2. Gastro-enterology, Two Weeks, starting October 16. Gastroscopy, Two Weeks, starting July 17, September 25.

DERMATOLOGY—Formal Course, Two Weeks, starting October 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting September 25. Cystoscopy, Ten Day Practical Course, every two weeks.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

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OBITUARY

William David Brinson

Dr. William D. Brinson of Baldwin died suddenly in his drugstore on April 15, 1950. Death resulted from a heart attack. He was 69 years of age. Interment took place in the family lot in Brinson, Ga.

The son of Peyton George Brinson and Queen Parramore Brinson, this prominent Baldwin physician and business man was born June 6, 1880 in Brinson, Ga. He received his premedical schooling at the University of Georgia, graduating in 1909, and his medical training at the Vanderbilt University School of Medicine, where he received the degree of Doctor of Medicine and was also a graduate in pharmacy. Upon graduation in 1913, he located in Baldwin and had since resided there.

Besides engaging in the general practice of medicine in Baldwin for thirty-seven years, Dr. Brinson served locally as surgeon for the Seaboard Air Line Railway and the Hercules Powder Plant. He was also prominently identified with the civic and social life of the community. In addition to owning the Baldwin Drug Company, he was president of the Brinson Turpentine Company at Maxville. He held membership in the Methodist Church and was affiliated with Baldwin Lodge 217, F. and A. M.

Dr. Brinson was a member of the Duval County Medical Society, the Florida Medical Association, the American Medical Association, the Southern Medical Association and the Seaboard Air Line Railway Surgeons. His hospital affiliations included St. Vincent's, St. Luke's and Brewster hospitals in Jacksonville.

In 1927, Dr. Brinson married Miss Marie Elizabeth Smith of Dillon, S. C., who survives him. Also surviving are a son, William D. Brinson, Jr., and his twin sister, Miss Harriett Elizabeth Brinson of Baldwin; his stepmother, Mrs. Elizabeth Brinson, also of Baldwin; a sister, Mrs. Florence Martin of Iron City, Ga.; and a brother, Dr. Peyton A. Brinson of Baldwin.

BOOKS RECEIVED

CLINICAL INTERPRETATION OF LABORATORY TESTS. By Raymond H. Goodale, M.D. Price, \$6.50. Pp. 605. Philadelphia: F. A. Davis Company, 1949.

The numerous advances in all branches of clinical pathology make it important today to have at hand an interpretative text. This working manual for the general practitioner, intern, technologist, nurse and student interprets the significance of the individual test and lists the diagnostic tests for each disease. Designed to bring together the laboratory and the clinic, the book is divided into two parts, the first entitled "Body Fluids, Excreta, and Functional Tests" and the second "Diseases with Associated Laboratory Findings."

Each disease which lends itself to laboratory diagnosis is briefly outlined and followed by a list of changes to be expected in the examinations which are given in order of importance. Diseases with associated laboratory findings are discussed according to the various systems. Among the topics fully discussed are the physiology, normal values, and significance of abnormal values of the various body fluids and excreta; basal metabolic rates; liver function tests; bacteriologic, viral and mycotic examinations; skin tests; poisons; chemotherapy and antibiotic therapy in relation to bacteriology; and proper methods of preparing body fluids, excreta, and tissues for the laboratory.



BREAST DEFORMITIES AND THEIR REPAIR. By Jacques W. Maliniac, M.D. Price, \$10.00. Pp. 193. New York: Grune & Stratton, Inc., 1950.

It is the twofold purpose of this book to present a complete and accurate commentary on the present status of mammaplastic surgery and to create a better understanding of the problems associated with breast deformities, thereby breaking down unwarranted prejudices against their reconstruction. Herein the surgeon, gynecologist and obstetrician, interested in this type of surgery but without special experience in the field, will find a guide to the safe procedures available for correction of breast deformities and to determination of the proper method for each individual case. The book is well illustrated.

The author is Clinical Professor of Plastic Reporative Surgery and Associate Attending Plastic Reporative Surgeon, New York Polyclinic Medical School and Hospital, New York City. Out of his extensive experience he evaluates present day methods, although aware that such an appraisal is a "touchy and unrewarding task." The critical evaluations are based on anatomic, physiologic and esthetic considerations, and a particular method is recommended only if it preserves all possible function of the breast and reproduces its normal form.



SEXUAL DEVIATIONS. By Louis S. London, M.D., and Frank S. Caprio, M.D. Price, \$10.00. Pp. 702. Washington, D. C.: The Linacre Press, Inc., 1950.

In the light of modern psychopathology, the experienced authors of this book present their subject interestingly and scientifically from the historical survey on through the various clinical manifestations to the therapeutic, prophylactic and social aspects of the problem. The material, presented in twenty chapters, is divided into three parts: (1) Theoretical Considerations: Genesis of Sexual Aberrations; (2) Clinical Data: Psychodynamics of Sexual Deviations; and (3) General Discussion: Therapeutic and Sociological Aspects.

(Continued on page 54)



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Since most of the well known textbooks on this subject are now of historical interest only, this book bringing to date what has been learned is most timely. A comprehensive reference based upon current material, it should be useful not only to psychiatrists and their helpers, but also to physicians and educators who need reliable information of this character.

The modern concepts of psychosexual pathology are clearly set forth, and in the case material, none of which is borrowed, particular stress is placed on the psychodynamics of each sexual deviation. The authors hope that the data presented, in the light of clinical research, will help the reader to develop a scientific appreciation of the "sexual deviate" who veritably is a sick individual blind to the true cause of his sexual affliction and in tragic need of psychiatric assistance.



CARDIOVASCULAR DISEASE, FUNDAMENTALS, DIFFERENTIAL DIAGNOSIS, PROGNOSIS AND TREATMENT. By Louis H. Sigler, M.D., F.A.C.P. Price \$10.00. Pp. 551. New York: Grune & Stratton, 1949.

Employing the method he has used in postgraduate teaching for many years, Dr. Sigler attempts in the thirty-one chapters of this text to cover all problems the physician is called upon to solve in the course of his practice, as submitted to the author in his capacity as consultant. Realizing the need for a proper understanding of the physiologic phenomena as related to clinical medicine, he devotes considerable space to such studies. In addition, appropriate attention is given to the etiology, anatomic pathology and pathogenesis of disease. Throughout the text the psychosomatic aspects of disease are stressed, and one chapter is fully devoted to this subject.

The clinical manifestations of the various diseases of the circulatory system, the diagnosis, and the differential diagnosis are covered in a clear, comprehensive manner. The newer methods employed in diagnosis, such as roentgenkymography, electrokymography, angiocardiology and cardiac catheterization are briefly presented. The prognosis is discussed in each instance from a viewpoint of the clinical manifestations in the given case.

Treatment is considered from a broad constitutional viewpoint, and the latest therapeutic measures are described in detail.



SAW-GE-MAIL (MEDICINE MAN). By Louis J. Garipey, M.D. Price, \$3.00. Pp. 326. Saint Paul, Minn.: Northland Press, 1950.

Saw-ge-mah, in the Ottawa Indian tongue meaning "Medicine Man," is the story of Hal Adams, who as a boy in a tiny lumber town in upper Michigan dreamed of becoming a physician and later through long and arduous years of medical study put forth unceasing efforts to become a successful practitioner. It might well be called "the story of every medical man," for it vividly portrays a pattern of life familiar to every physician and brings to mind innumerable nostalgic memories. Recreated and relived are the challenging fact-filled years in medical school, the grueling pace of an internship, the stimulating responsibilities of a residency, the worried hours and the rewarding experiences of private practice. Interwoven is a thorough discussion of the major problems encountered in the field of medicine, presented with warmth and understanding.

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JOURNAL

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Marianna, Oct. 30, 1950
B-Northeast	Cleland D. Cochran, Daytona Beach	Eugene G. Peek, Jr., Ocala	Ocala, Nov. 1, 1950
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Ft. Myers, Nov. 2, 1950
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	West Palm Beach, Nov. 3, '50
Florida Specialty Societies			
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	Hollywood, Apr. 22, '51
Anesthesiologists, Soc. of	Colquitt Pearson, Miami	Harold Carron, Tampa	" "
Chapter, Am. Acad. Gen. Prac.	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Genec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	V. Marklin Johnson, W. Palm Beach	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" "
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 11, '50
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamrock, Gainesville	
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	November, 1950
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Denver, Nov. 28-Dec. 1, '50
Southern Medical Association	Hamilton W. McKay, Charlotte, N.C.	Mr. C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James M. Crews, Memphis	Mr. L. H. Gunter, Montgomery	
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	June McCafferty, Mobile, Ala.	Mobile, Ala.

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A

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Daniel M. Adams, Jr., M.D. Box 593 Panama City	Jack Corbitt, M.D. Box 961 Panama City		17	16	A-1-52 Arthur J. Butt, Jr., M.D. Pensacola
Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1161 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	68	
Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	16	
Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	16	
Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	47	44	
Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		7	100%	
Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	3	
Taylor *Dixie-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	212

B

Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 825 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	44	43	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	241	226	
Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	28	100%	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	10	100%	
St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	B-4-51 Cleveland D. Cochrane, M.D. Daytona Beach
Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	18	100%	
Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	22	100%	
Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	138	131	
Seminole	Charles L. Park, M.D. 212 N. Park Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	59	54	593

C

Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	155	147	C-5-51 M. Crego Smith, M.D. Clearwater
Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	20	
Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	100%	
Pinellas	Albert R. Frederick, M.D. 408 Florida Power Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	171	169	
Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	38	100%	
DeSoto-Hardee- Highlands- Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	24	C-6-52 Leldon W. Martin, M.D. Sebring
Lee-Charlotte- Collier-Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	26	24	
Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	83	76	532

D

Indian River	Melton D. Council, M.D. Box 983 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-52 Adrian M. Sample, M.D. Fort Pierce
Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	97	96	
St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	15	100%	
Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	74	73	D-8-51 S. Marion Salley, M.D. Miami
Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	537	460	
Monroe	Herman K. Moore, M.D. 600 Elizabeth St. Key West	Allen S. Shepard, M.D. 403 Caroline St. Key West	2nd Thursday 8:00 P.M.	11	10	741

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OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

AUGUST, 1950

No. 2

IN THIS ISSUE

THE N.Y. ACADEMY
OF MEDICINE
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Venous Thrombosis

Alton Ochsner



Pelvic Malignant Disease

Emil Novak



Aims and Creed of American Medicine

An Editorial



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Smadel, J. E.: J.A.M.A. 142:315, 1950 (discussion)

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Hewitt, W.L., and Williams, B., Jr.: New England J. Med. 242:119, 1950

toxic reactions or signs of intolerance were observed."

Payne, E. H.; Knaudt, J. A., and Palacios, S.: J. Trop. Med. & Hyg. 51:68, 1948

symptoms or signs of toxic effects attributable to the drug were observed."

Ley, H. L., Jr.; Smadel, J. E., and Crocker, T.: Proc. Soc. Exper. Biol. & Med. 68:9, 1948

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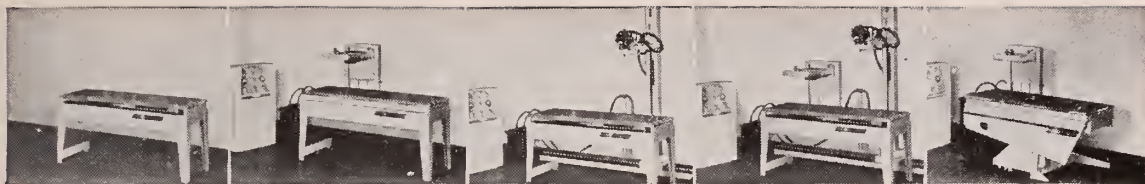
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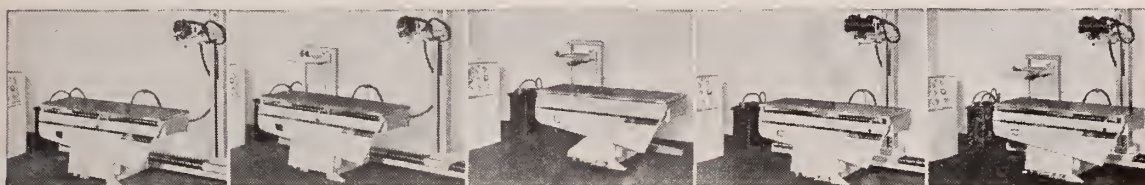
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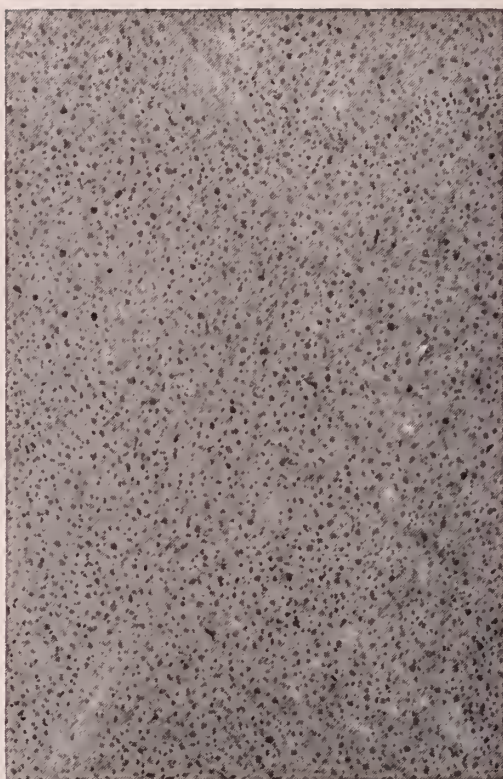
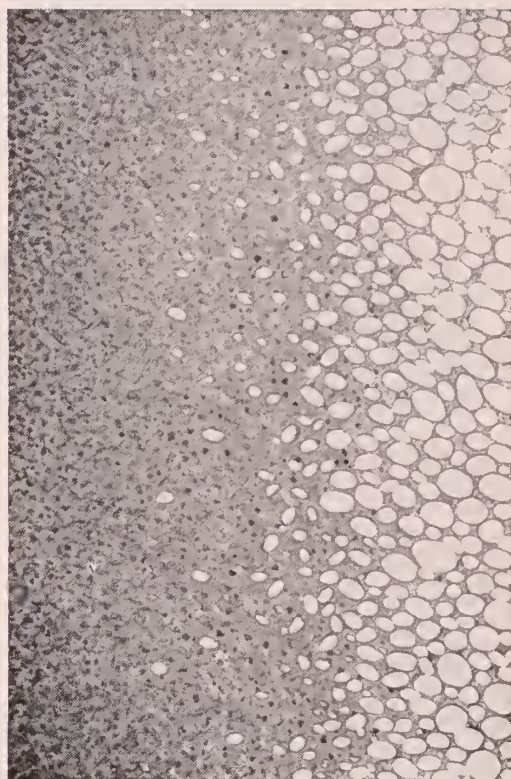
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1. Beckman, H.: Treatment in General Practice. Philadelphia, W. B. Saunders Co., 1946, p. 103.
2. Laeb, R. F. (Chairman, Board for Coordination of Malarial Studies) et al: Activity of a New Antimalarial Agent, Chloroquine (SN7618), J.A.M.A., 130:1069, Apr. 20, 1946.



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Hamblen, E. C.: Some Aspects
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in General Practice,
North Carolina M. J.
7:533 (Oct.) 1946.



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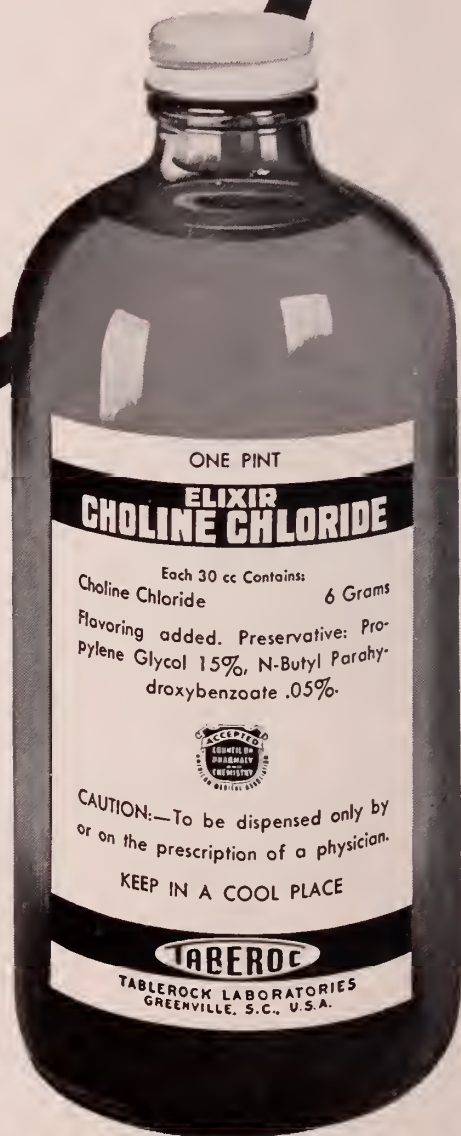
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Venous Thrombosis

ALTON OCHSNER, M.D.*

NEW ORLEANS

MICHAEL E. DeBAKEY, M.D.**

HOUSTON, TEXAS

AND

PAUL T. DeCAMP, M.D.*

NEW ORLEANS

Venous thrombosis has become increasingly more significant to physicians and surgeons alike because of the devastating effect which it has upon patients in whom this complication develops. The importance of venous thrombosis in surgical patients is relatively greater than previously because with the control of infection and shock, which were formerly the most frequent causes of postoperative death, fatalities and disabilities produced by venous thrombosis occupy a more important place.

Thrombophlebitis and Phlebothrombosis

For many years, we have been interested in the subject of venous thrombosis and have become convinced that it is essential to differentiate between two types which are different from the standpoints of etiology, pathology, clinical manifestations, prognosis and therapy. In fact, the only feature they have in common is the clot within the vein. Thrombophlebitis is a condition in which there is inflammation of the wall of the vein and in which the clot is secondary to the inflammatory process. The clot is firmly attached to the wall of the vein and is not likely to become detached except in the relatively rare instances of suppuration in which the clot detachment is the result of liquefaction of the clot. The symptoms in thrombophlebitis are, however, severe, consisting of pain, fever and swelling of the extremity. Although death following nonsuppurative thrombophlebitis, or phlegmasia alba dolens, is relatively infrequent, the sequelae which persist, unless adequate therapy is used during the acute attack, are likely to be disabling.

On the other hand, phlebothrombosis in which a coagulation thrombus forms within an otherwise normal vein is associated with few or no manifestations because there is no inflammation of the wall of the vein. The clot is loosely attached and can be detached readily, which fact is responsible for pulmonary infarction and fatal pulmonary embolism. There are probably two causes of phlebothrombosis, one predisposing and one precipitating. The former consists of alterations in the blood which favor coagulation, which undoubtedly are the result of tissue injury regardless of the cause. The latter is circulatory stasis and is responsible for the high incidence of phlebothrombosis in the veins of the lower extremity in which the blood flow is frequently retarded.

In the past, the attention of most investigators has been directed toward controlling the precipitating factor, circulatory stasis, and it is for this reason that patients who are candidates for the development of venous thrombosis have been treated in such a way as to speed up the blood flow in the venous system. Early ambulation has been practiced, and for those patients who were not able to get out of bed, active contraction of the muscles of the extremities against a resistance was urged. In order to accelerate the blood flow through the deep venous system, compression bandages were applied to the lower extremities from the toes to the groins. Emphasis has been placed upon the necessity of avoiding abdominal distention and compression to prevent compression of the large veins within the abdomen which would favor stasis of the blood in the veins of the lower extremity. Deep breathing has been practiced in order to facilitate the return of the venous blood to the heart by increasing the negative pressure within the thorax. In some instances, anticoag-

Read before the Florida Medical Association, Seventy-Sixth Annual Meeting, Hollywood, April 25, 1950.

*From the Department of Surgery, Tulane University of Louisiana School of Medicine, and the Ochsner Clinic, New Orleans.

**From the Department of Surgery, Baylor University College of Medicine, Houston, Texas.

ulants have been used to overcome the changes in the blood which predispose to clotting. Although theoretically desirable, their routine use is hazardous because of the great danger of the hemorrhagic tendency which they produce.

In addition to measures instituted to prevent the formation of venous thrombosis, a constant vigilance has been maintained on our surgical service to detect the early development of venous thrombosis, particularly phlebothrombosis, in order that prompt thrombectomy and ligation of the vessel might be accomplished before the clot became detached. Although this effort has been successful in a large number of instances in that venous thrombosis has been elicited and patients operated upon successfully, unfortunately it has not been possible to detect the presence of phlebothrombosis in all cases.

Analysis of Cases

Whereas we were of the opinion that the results which we obtained from the outlined prophylactic and therapeutic regimen in venous thrombosis were satisfactory, it was not until we had made a careful survey of all the cases at the Charity Hospital that we realized our results were far from satisfactory and that there was need for additional measures to prevent the development of venous thrombosis. There were 1,002 cases of venous thrombosis in the Charity Hospital on all services in the eleven year period from 1938 to 1949 inclusive. During this time, 582,726 patients were admitted to and 172,959 operations were performed in the Charity Hospital. There were 29,494 deaths and 9,809 autopsies, an autopsy incidence of $33\frac{1}{3}$ per cent. There were 411 cases with fatal pulmonary embolism, in 342 of which the diagnosis was confirmed by autopsy. On the basis of 100 per cent autopsy incidence, the anticipated number of fatal pulmonary embolisms would be 1,026. The actual incidence of fatal pulmonary embolism in all the cases was 0.071 per cent, and the expected incidence was 0.176 per cent.

There were 87 postoperative cases in which fatal pulmonary embolism developed; of this number, the diagnosis in 58 was confirmed by autopsy. The expected number would be 174 (actual frequency 0.05 per cent and expected incidence 0.101 per cent).

Although the incidence of fatal pulmonary embolism is not high, it is of significance that in the Charity Hospital, in which the staff has been interested in venous thrombosis for a number of

years, the incidence of thromboembolism and fatal pulmonary embolism has increased progressively in recent years. Whereas from 1938 to 1942 there were 117 cases of thromboembolism for 100,000 admissions to the hospital, the number increased to 186 in the period from 1942 to 1946, and to 237 in the period from 1946 to 1949. Similar increases, although not as great, occurred in the incidence of fatal pulmonary embolism. The number of cases per hundred thousand were as follows: from 1938 to 1942, 56; from 1942 to 1946, 63; and from 1946 to 1949, 98. It is thus seen that in an institution in which, even though prophylactic measures have been used to prevent the development of venous thrombosis and to prevent the detachment of the clot once it has formed, there has been a progressive increase in the incidence of thromboembolism and of fatal pulmonary embolism. It is true that the total increase in thromboembolism has been greater than the increase in fatal pulmonary embolism.

The racial distribution is not particularly significant except that thrombosis without embolism occurred more frequently in white persons than in Negroes, whereas fatal pulmonary embolism was slightly more frequent in the Negro than in the white race. The reason for this difference is not evident.

The sex relationship is of interest. Whereas the total number of cases of thromboembolism was approximately the same in the two sexes, thrombosis without embolism occurred much more frequently in women than in men, and fatal pulmonary embolism was much more frequent in men than in women. The higher incidence of thrombosis without embolism in women is probably due to the fact that true thrombophlebitis, or phlegmasia alba dolens, occurs frequently as a postpuerperal complication. On the other hand, the higher incidence of fatal pulmonary embolism in men is probably due to the fact that men are more susceptible to coronary thrombosis, which is associated with a high incidence of fatal pulmonary embolism.

In New Orleans in contrast to some other communities, there was no seasonal variation in the incidence of thromboembolism. This is probably because there is little variation in the seasons as is true in Florida. In a little over half the cases the left leg was involved, in a little over a third the right leg was involved, and in the remainder the involvement was bilateral.

The relationship of the number of cases of

thromboembolism and the total admissions to the various services was interesting. There was a parallelism on the medical, the surgical and the urologic services. There were two services in which this parallelism was not observed, the obstetric and the gynecologic services. Although 20.2 per cent of all the admissions were to the obstetric service, only 9.8 per cent of the cases of thromboembolism occurred on this service. Whereas 8.7 per cent of all the admissions to the hospital were to the gynecologic service, 18.1 per cent of the cases of thromboembolism occurred on this service. This difference may be more apparent than real and may be due to the fact that cases of suppurative pelvic thrombophlebitis following criminal abortion are admitted to the gynecologic service, for these admissions undoubtedly increase the incidence on this service.

Pulmonary embolism complicated heart disease more than any other condition. Whereas only 26.9 per cent of all the cases of thromboembolism occurred in patients with heart disease, 44.5 per cent of the cases of pulmonary embolism occurred in this group of patients. Twelve and two-tenths per cent of all cases of thromboembolism occurred on the obstetric service, whereas only 5.9 per cent of the cases of pulmonary embolism occurred on this service. This difference is undoubtedly due to the fact that obstetric cases have true thrombophlebitis or phlegmasia alba dolens in which the clot is firmly attached to the wall of the vein and does not become detached with the development of pulmonary embolism. On the other hand, in a patient with heart disease phlebothrombosis, which is frequently complicated by pulmonary embolism, is particularly likely to develop.

In comparing all the fatalities in the hospital with those caused by pulmonary embolism, an interesting parallelism is observed in various hospital services with the exception of the tuberculosis and gynecologic services. The higher incidence of fatal pulmonary embolism as compared with the percentage of all the fatalities occurring on the gynecologic service is obvious for the reason which has been mentioned before, namely, that a large number of cases of suppurative thrombophlebitis are admitted to the gynecologic service and until recently the mortality rate in these cases has been extremely high. With the prompt recognition of pelvic suppurative thrombophlebitis, however, and the early ligation of the inferior vena cava and the ovarian veins, the mortality rate can be and has been markedly

diminished. It is difficult to explain why the incidence of fatal cases of pulmonary embolism on the tuberculosis service is much lower than on the other services. Whereas 10.5 per cent of all the fatalities in the hospital occurred on the tuberculosis service, only 1.5 per cent of the cases of fatal pulmonary embolism occurred on this service.

The danger of venous thrombosis is illustrated by the fact that of the 1,002 cases of thromboembolism occurring in the eleven year period from 1938 to 1949, 411 (41 per cent) ended fatally. This number illustrates the seriousness of venous thrombosis and emphasizes the necessity for the institution of measures to control it. The fatality incidence was highest on the medical service, 68.4 per cent, and lowest on the obstetric service, 7.4 per cent. The fatality incidences on the other services were as follows: urology, 44.6 per cent; gynecology, 27.5 per cent; and surgery, 22.3 per cent.

As mentioned previously, it has been our hope that by the institution of measures to prevent circulatory stasis and by early detection of venous thrombosis and prompt ligation of veins to prevent the detachment of a clot, (all patients who were thought to be likely candidates for venous thrombosis were carefully examined several times daily for evidence of venous thrombosis), this serious complication could be controlled. In only 50.8 per cent of the cases of septic venous thrombosis, however, and in 56.8 per cent of the cases of nonseptic venous thrombosis was there clinical evidence of the existence of a clot before fatal pulmonary embolism occurred. The fact that in over 40 per cent of instances it was impossible to make a clinical diagnosis of venous thrombosis before the clot detached and produced a fatal pulmonary embolism illustrates the need of some other method than clinical examination to determine which patients have venous thrombosis or are candidates for it.

Prothrombin-Antithrombin Relationship

Approximately two and a half years ago, we turned our attention toward a more detailed study of the fundamentals concerned with venous thrombosis. During this time, Dr. John Kay has devoted almost his entire time to this study. As a result of these investigations, it is evident that intravenous clotting of the phlebothrombotic type occurs when there is a disproportion between prothrombin and antithrombin in the blood. Although prothrombin is necessary for blood coagu-

lation, it is possible for a clot to occur even though the prothrombin level may be low, provided the antithrombin content is proportionately lower. Normally, venous thrombosis is apparently prevented by a balance being maintained between prothrombin and antithrombin. It is our belief that as a result of tissue injury, and apparently it is immaterial what the cause of the injury is, the antithrombin content of the blood is decreased; if continued, this decrease may cause sufficient disproportion between the prothrombin and antithrombin contents of the blood to permit thrombosis. We have shown by the antithrombin determination preoperatively and on successive days postoperatively that plasma antithrombin is diminished in the postoperative period. In most cases, the antithrombin level returns to normal after a period of four to five days. In the cases, however, in which there is a progressive fall in the antithrombin postoperatively, phlebothrombosis is likely.

In the past eight months we have studied 228 patients who have been subjected to major surgical procedures and in whom the development of phlebothrombosis was possible. Of this group, 140 had antithrombin levels of 1:16 or greater, and thrombosis or embolism developed in none. Eighty-eight patients had antithrombin levels less than 1:16. Of these, 32 simultaneously had prothrombin times of less than 20 seconds (50 per cent of normal), in 19 of whom there developed intravascular clotting; 4 had fatal pulmonary embolism; 1 died of cerebral thrombosis (this patient had an antithrombin level of 1:4 and a prothrombin time of 39 seconds); and 1 had a non-fatal pulmonary embolism five days postopera-

tively with an antithrombin level of 1:16 and prothrombin time of 15 seconds.

Early in his investigations, Dr. Kay showed that alphanatophenol when combined with calcium is an effective antithrombin and because of this fact, we have used it in a series of cases. In 110 cases in which it has been used, there have been no antithrombin levels less than 1:16. No intravascular clotting developed, with the exception of 1 case. The patient in this case had a nonfatal embolism on the second postoperative day and died from a pulmonary embolism on the tenth postoperative day. She had a pneumonectomy for carcinoma of the lung, and it is our belief that phlebothrombosis developed before she was operated upon, because the nonfatal embolism occurred earlier than it should have had the venous thrombosis developed in the postoperative period. On the second postoperative day, there developed cyanosis and dyspnea which were coincident with oxygen removal, and it was erroneously considered that the respiratory distress was caused by removal of the oxygen. On the tenth postoperative day, however, she had a massive pulmonary embolism and died. Autopsy showed that there were two types of emboli within the pulmonary vessels, one older, which undoubtedly occurred on the second postoperative day and the other more recent, which was the cause of death. This case illustrates that a normal antithrombin level is no assurance that a clot has not already formed. The clinical evidence of venous thrombosis as presented in this patient at the time of the respiratory distress on the second postoperative day should have been an indication for venous ligation.

Ochsner Clinic,
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ANNOUNCEMENT MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. Lloyd J. Netto, has announced that the dates of the four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to make a note of these dates and make plans to attend the meeting in his district and any of the other three meetings as desired.

Marianna, Monday, Oct. 30, 1950
Ocala, Wednesday, Nov. 1, 1950

Fort Myers, Thursday, Nov. 2, 1950
W. Palm Beach, Friday, Nov. 3, 1950

Treatment of Pelvic Malignant Disease

EMIL NOVAK, M.D.
BALTIMORE

While the topic of this paper is not of my own selection, it is one in which I am greatly interested, and one which I was therefore glad to accept. It is a comprehensive one, and I know that, instead of having me skip superficially over all possible forms of pelvic malignant disease, you would prefer to have me select for discussion only the most common and most important. Even these constitute a big assignment for a short paper, which will therefore be limited to an appraisal of the broad principles of treatment in this field, with necessary and probably desirable elimination of statistics and technical descriptions of both the surgical and radiotherapeutic procedures which constitute our chief weapons against these diseases.

The most important of all gynecologic problems is that of cancer of the uterus. Each year it kills about 17,000 women in this country, a greater toll than is exacted by any form of female cancer except mammary carcinoma. The clinical and pathologic characteristics of the three types of uterine carcinoma, the new but still confused field opened up by the study of precursory or preinvasive lesions, the roles played by the newer aids to diagnosis, such as vaginal cytologic studies, as supplements to the tried, true and decisive method of biopsy—all these and many more aspects of the general problem invite discussion, but they must be set aside in a paper devoted to therapy alone.

Cancer of the Cervix Uteri

Before the advent of radium into the field of cancer therapy, the problem of the gynecologist faced with the treatment of a cancer of the cervix was a comparatively simple one, in so far as selecting the wisest plan of treatment was concerned. He had only to decide whether or not the patient was operable, and one can understand how frequently this judgment was influenced by the clinician's own conservative or radical trend,

as the case might be. There were some who considered as operable almost any patient in whom the pelvic organs could be removed without too great a hazard, even though the operation might be expected to be difficult and hazardous, and the prospects for cure relatively poor. Such gynecologists might have an operability rate of 50 per cent or more. The more conservative surgeon, on the other hand, might select for operation only those in whom the operation did not promise to be forbiddingly hazardous, and for whom there seemed to be at least a reasonable hope of cure. Such men might select only 20 per cent or so of their patients for the surgical attempt.

The patients rejected for operation were literally condemned to death by the palliative route. The Paquelin cautery and later the electrocautery and the acetone method of Gellhorn were the two chief methods until the advent of radium. As a matter of fact, it was only as a palliative that radium was first employed in the therapy of cervical cancer. It proved to be a better one than the older agents, and every now and then a surprising cure was obtained. It is also true that with a good many patients of that day more harm than good resulted from its use, for radiotherapeutic technic was undeveloped, and extensive visceral injury, with frequently the production of genital fistulas of one sort or another, was all too common.

On the whole, however, the results were sufficiently satisfactory to induce many to extend the employment of radium to the borderline group of cases with even better palliative results, and with a higher percentage of cures. It is not surprising, therefore, that it soon found application in even the early and favorable group, those in which the trained surgeon could expect a cure in at least half by radical operation. This measure consisted of complete removal of the uterus and adnexa, resection of a large cuff of vagina and as much parametrium as possible, and dissection of the pelvic glands. The high primary mortality of such a formidable procedure in those days led to

the later adoption by most surgeons of a more restricted procedure, in which gland excision was omitted. A few brave souls, however, notably Bonney and his disciples in London, have continued to perform the more radical procedures from the early preradium days up to the present time. I am old enough to have gone through at least the latter part of this early phase of radical surgery for cervical cancer, and to feel sure that most surgeons of the day were unenthusiastic about this method of treatment, employing it because there was no other choice. They were willing enough to give it up for radium, which soon was all but universally adopted as the method of choice, although in many clinics in an occasional selected case treatment was surgical.

Without reviewing the statistics of those days, it soon became clear that while radium did not cure a higher proportion than could be cured by the expert surgeon, it cured just about as many. Moreover, and this is what gave it a clear advantage, it rarely killed the patient, while even in the hands of the trained surgeon the primary mortality following surgical intervention was high, something like 10 to 15 per cent, and with the less skillful much higher, 20 to 25 per cent, not to speak of the high incidence of such sequelae as fistulas of one sort or another. Small wonder, therefore, that radium soon came to dominate this therapeutic field, and that in some of our large hospitals the members of the house staff saw not a single radical operation during their residencies.

About four years ago there began a resurgence of the surgical plan upon the comparatively early and more favorable group of cases, those of clinical Stage 1 and in the practice of some, a fraction of the Stage 2 cases. This return to the radical surgical plan, which had been found inadequate in the hands of such masters as Wertheim and Kelly, might at first thought have seemed indefensible. As was, however, properly urged by Meigs and others, it was justified by the fact that such modern surgical adjuvants as transfusion, antibiotics and chemotherapy should greatly minimize the high primary mortality which had formerly been a drawback even in the hands of the old masters. That this is true has already been demonstrated in the reports of Meigs and others, but it is too early to know whether the final results of the radical operative plan will be sufficiently better than the radiotherapeutic plan to justify its general adoption. They will have

to be especially good to do this, since the survival rates with the newer radiotherapeutic technics in clinically comparable cases have become surprisingly high, as high as 70 per cent.

There are still many unsettled aspects of this problem, such as the question of whether or not even the most expert irradiation can be expected to have any effect upon involvement of the pelvic glands. On the other hand, the glands do not form an impassable barrier to the disease, and their removal in cervical cancer can no more be considered to offer an assurance of cure than can the removal of involved axillary glands in mammary cancer. As to the latter, not many general surgeons are particularly enthusiastic.

Other points which have to be pitted against each other are the morbidity rates associated with the two plans of treatment. Nothing is more certain than that any widespread adoption of the formidable operations, including extensive gland dissections, urged by the surgical group, will inevitably be attended by a high incidence of such complications as vesical and ureteral fistulas, to mention only the most important. On the other hand, and in spite of steady improvements in radiotherapeutic technic, it has not been possible to eliminate the hazards of distressing and sometimes grave visceral damage.

For the present, and on this point all but a few will agree, radiotherapy remains the choice in the overwhelming majority of cases of cervical cancer as they present themselves, since the proportion of Stage 1 cases is so comparatively small, making up only 10 to 12 per cent of the total. Even in this comparatively small group, many continue to believe that on the basis of available statistics the radiotherapeutic plan is still the one to be preferred. In a recent paper by Read, the disciple and to a considerable extent the successor of Victor Bonney in the London stronghold of radical surgery, a general concept of the role of surgery in this field was given which impresses me as both more conservative and more rational than that held by some of our American champions of surgery for this disease. He lists the following indications for the radical operation: (1) radioresistant growths, (2) columnar cell carcinoma of the cervix, (3) stenosis of the vaginal vault, (4) the presence of large fibroids or ovarian cysts complicating the cervical cancer, (5) salpingitis complicating cervical cancer, (6) refusal of radiation by the patient and (7) pregnancy complicating cervical cancer. The most significant of these

indications, as contrasted with the more radical trend of some American gynecologists, is represented in (1), since it indicates that Read's initial treatment in most cases is irradiation. Only if the lesion shows radioresistance, on the basis of clinical or cytologic evidence, does he resort to the radical operation.

As for the radical surgery recently applied even in greatly advanced cases, especially by Brunschwig, I shall say little, since it must be looked upon as merely experimental. Only a few years ago it would have been considered wholly indefensible, almost criminal, for a surgeon to resort to radical surgery in far advanced or even hopeless stages of cancer. And yet just this plan is embodied in the so-called All-American operation of Brunschwig, in which all the pelvic contents are removed, including the uterus and its adnexa, the bladder and the rectum, with colostomy and implantation of the ureters into the bowel. The chief justification for this operation on the part of its author is that it relieves the patient's pain and adds to her comfort, a radical type of palliation, to speak paradoxically. It is scarcely necessary to warn against extensive adoption of this plan for the present, if for no other reason than because of the magnitude and the expensiveness of this procedure, in which, for example, extremely large amounts of blood must always be available. It is scarcely necessary here to discuss the rationale and the justifiability of this procedure, and Brunschwig and his still small group of followers must be left to work out their heroic little experiment and report to us later.

Endometrial Carcinoma

Coming now to adenocarcinoma of the corpus uteri, we again encounter changing trends and a greater tendency to combinations of radiotherapy and surgery rather than a reliance upon either alone. With cervical cancer, as I have already discussed, radiotherapy was until recent years the almost universal choice, surgery being selected for only the occasional favorable case. With adenocarcinoma of the endometrium, the plan was almost exactly opposite. Radical operation was the almost universal plan, and radiotherapy alone was used only in cases in which the extent of the disease or the poor general condition of the patient contraindicated surgery. Even the advent of radium did not change this general policy in most clinics, although in a few, notably the Radiumhemmet of Stockholm, the accepted plan for

many years was the combination of intracavitary radium with external radiation.

The curability rate obtainable by radical operation in corporeal carcinoma has always been in general substantially higher than for cervical cancer, and the surgical procedures involved have been much less difficult and hazardous. During the last five years or so efforts to improve results have been made through combinations of irradiation and surgery. The former alone cannot be depended upon, the experience of most clinics showing that after presumably adequate intracavitary radium dosage, residual carcinoma in the removed uterus may be expected in something like 50 per cent of cases. On the other hand, there is no doubt that preliminary irradiation, in addition to sterilizing the uterine cavity, inactivates or destroys much of the cancer tissue, and that the fibrosis which it produces may entrap many cancer cells and thereby lessen the hazard of operative dissemination of these cells. For such reasons as this the generally recommended plan of the moment is to precede operation with irradiation done six or eight weeks previously. Either intracavitary radiation or external roentgen therapy may be used for this preliminary treatment, but on the indispensability of hysterectomy as a part of the treatment there is now almost universal agreement.

There is, however, an increasing number of dissenters from the view that preliminary irradiation should be a necessarily routine procedure. I myself do not always employ it. In the earlier group of cases in which curettage yields only a small amount of tissue and the uterus is small, but the diagnosis can be made with reasonable certainty by the gross appearance, I see no advantage, and on the other hand considerable psychologic and economic disadvantage, to the patient in subjecting her to radiotherapy and deferring the radical operation for a couple of months. In such cases it seems sensible to me to proceed at the same sitting with the radical operation. If the cervix is tightly closed with sutures and the broad ligaments clamped as the first step of the abdominal procedure, the risk of disseminating cancer cells should be nil. Nor do we need to be concerned by the fear of peritonitis, now an almost negligible hazard of such operations.

On the other hand, in the more advanced cases, in which the uterus is greatly enlarged and its cavity filled with necrotic fungoid material, the rationale of preliminary irradiation seems

clearer, and I employ it in such cases. The question, therefore, is still a rather open one, and one probably calling for some individual considerations rather than a stereotyped acceptance of the combination plan of treatment, now recommended by some of our leading gynecologists.

Ovarian Cancer

The only other form of genital malignant disease to which there is time to make at least brief reference is that of ovarian cancer, which ranks next to uterine cancer among the malignant diseases of the female genital organs, but exceeds the latter in deadliness. Whether this higher degree of malignancy is intrinsic to the disease itself or whether it is largely explainable by its insidiousness it is difficult to be sure. Carcinoma of the cervix is to all intents an external disease, the cervix being readily accessible for diagnostic study. Furthermore, in a majority of cases, though unfortunately not all, it gives rise to at least the abnormal bleeding which will impel the alert patient to seek examination. With ovarian cancer, on the other hand, there is ordinarily no pain and no bleeding, and in a considerable proportion of cases it is the lump in the abdomen which first draws the patient's attention to the possibility of trouble. By this time the disease is likely to be in an advanced or even hopeless stage. For that matter, it is not uncommon for the patient to have no suspicion of trouble until the development of ascites, the result of peritoneal carcinomatosis.

The primary treatment of ovarian cancer is surgical, and it need hardly be emphasized that this should be radical, including removal of the uterus, tubes and ovaries. All too frequently, however, the extent of the disease as revealed at operation makes complete removal of the gross disease impossible. The ovarian tumor, often bilateral, may have infiltrated adjoining pelvic structures so extensively that its complete removal would be too hazardous or technically impossible. In other cases unsuspected metastases are found, especially on the peritoneum and in the omentum. There is general agreement that even in such advanced and apparently hopeless stages of the disease its progress is at least retarded by removal of the primary ovarian lesion or as much as appears feasible and safe.

Following operation for ovarian cancer, the almost universal plan is to employ postoperatively high voltage roentgen therapy, but I believe that

many surgeons do so rather unenthusiastically, and because it is about the only rational measure left which may conceivably prolong the patient's life and lessen her discomfort. It is difficult to be sure just how much it helps, chiefly because of the clinical vagaries so common with ovarian as well as other forms of cancer. In any event, post-operative irradiation is more rational than is the employment of testosterone, for which I see little rationale in this form of cancer.

There are certain relatively uncommon types of ovarian malignant disease in which a much less radical plan of treatment is sometimes justified. I refer to the so-called dysontogenetic group of tumors, embracing granulosa cell carcinoma, dysgerminoma and arrhenoblastoma. As a group the degree of malignancy of such tumors is much less than that of the ordinary primary ovarian cancers, and when such growths occur in very young women, and when they are of small size and well encapsulated, a conservative unilateral operation is justified. All these neoplasms, however, have wicked potentialities, and in women in whom preservation of the reproductive function is not especially important, the radical operation should be chosen.

Evaluation of Therapeutic Measures

This is only a sketchy view of the available plans for lessening the ravages of the chief forms of genital cancer. Surgery and irradiation therapy, whether singly or in combination, constitute our only weapons and have saved the lives of thousands of women. The technics for their employment are constantly being improved, with definite but not brilliant improvement in results, especially with the earlier group of cases. A depressing aspect of the problem, however, is that the over-all salvage for cervical cancer is still somewhere between 25 and 30 per cent, just about where it was fifty years ago. Many of us think that both surgery and radium, valuable as they have been, are makeshifts which some day will give way to some form of more specific therapy.

Until this happy day, there is one way which is wide open to us for a far greater improvement in results than is likely to accrue in the foreseeable future from extension of surgery or improvement in irradiation technic. I refer of course to the importance of increasing the proportion of patients in whom treatment can be begun in an early and favorable stage. This subject has been preached so long and so widely that it seems al-

most banal to urge it again. In spite of all our cancer campaigns, deadly delay in the institution of treatment is the usual rule, as the recent report of Howson and Montgomery has again graphically emphasized. The skirts of our own profession are not by any means clear, as this same report has shown that of the 78 per cent of cancer cases in which a delay of from seven to nineteen months occurred, in 28.3 per cent it was clearly chargeable to the physician. This report, it might be added, was not compiled from the records of dead patients, but was based on direct interviews with living cancer patients and their attending physicians. In my own judgment, the most important single means by which the woman can protect herself from this often practically symptomless disease is a competent gynecologic examination at intervals of preferably six months. Such periodic examinations are a nuisance to the woman, and they are disagreeable, but they will often be life-saving.

Conclusions

For the vast majority of cases of cervical cancer irradiation therapy is still to be preferred, on the basis of available statistics as to salvage rates and also the incidence of therapeutic complications. On the other hand, there is definite justification for radical surgery in a selected group of cases in which the disease is in an early stage, meaning usually Stage 1 and perhaps a fraction of Stage 2 cases, assuming that the surgeon is well trained in the technic of the radical procedure. The immediate mortality should in these days be low, but we do not as yet know what the ultimate rate of cure will be and how it will compare

with the really good results now being obtained by radiotherapy in corresponding stages of the disease.

As regards endometrial carcinoma, hysterectomy, with of course removal of the adnexa, is the most important part of the treatment, and should always be employed unless contraindicated by the hopelessly advanced stage of the disease or by the age or general debility of the patient. Available statistics, not yet extensive, indicate the advantage of preceding operation by irradiation. There are some, including myself, who do not believe that this should be an inflexible rule, as has been discussed in the paper.

Surgery for cancer of the ovary should obviously be radical whenever possible. Unfortunately, complete removal of all gross cancer tissue is frequently impossible, especially when peritoneal and other metastases have occurred. Even under these conditions, the removal of the primary lesion, or as much thereof as possible, is desirable and appears to retard the progress of the disease. Postoperatively high voltage roentgen therapy is to be recommended, although it is difficult to evaluate or to predict its degree of effectiveness.

The popular education of women, as well as continued education of our own profession, offers more hope of improving results than any other measure since it should increase the proportion of early and therefore favorable cases. Especially valuable in this respect would be a greater popularization of periodic examinations, preferably at intervals of six months.

26 East Preston Street.

**The Scientific Department of The Journal
Reflects the Experience of You
and Your Colleagues**

**The Editor Invites Your Contributions
On Data of Notable Interest**

Visual and Retinal Complications Of Diabetes Mellitus

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JACKSONVILLE

Among the diseases of metabolism, diabetes mellitus is the one with which the ophthalmologist is probably most concerned. Since this disease often occurs in conjunction with hyperthyroidism, arteriosclerosis, vascular hypertension and nephritis, its study at times becomes most intricate, bringing the ophthalmologist into close association with his colleagues in other branches of medicine and making his findings of particular interest to them.

Duration in Relation to Complications

Reviewing the literature leaves no doubt of the consensus that diabetic retinopathy is a degenerative disease, and that duration rather than severity of the diabetes mellitus apparently influences the retinal complications. It seems truly unfortunate that although medical science has been able to prolong the life of diabetic patients, the disturbance in the retina appears to bring on increasing complications as the diabetes continues to be present over a lengthening period of time.

Studies from various clinics indicate that in the group of patients suffering from diabetes mellitus for fifteen years or more, at least 40 per cent will have some form of diabetic retinopathy. The percentage rises to 85 per cent for the group who have had this disease for twenty-five years or more. In fact, Dolger¹ in reporting a recent series stated: "Within a period of twenty-five years' duration of diabetes mellitus not 1 of 200 regularly examined patients escaped retinal hemorrhage, regardless of age of onset, severity of diabetes or type of treatment used." These statistics mean, of course, that although the life of the diabetic patient has been prolonged by proper management of the disease, the chances of good vision decrease as time goes on. Recently, several authors have stressed the steadily increasing diabetic retinopathy in the younger age groups.²

Now that it is known that the duration of the

diabetes has more to do with retinal complications than the severity of the disease, it is my sincere hope that the ophthalmologists who are members of this Society, and any nonmembers who may be interested in this presentation, will review their records, study carefully their series of cases of diabetic retinopathy and be sure that hereafter they accurately record in each case the time at which diabetes mellitus was first diagnosed, if they have not routinely done so. By so doing, they will make available many more accurate records which will be helpful in this study in the future. Even after diabetes has been diagnosed, there is of course no telling how long it has existed prior to the diagnosis.

When the duration of the disease exceeds ten years, I believe the patients should be given some form of warning that will not cause undue alarm. They should be told to report any disturbance in vision and should thereafter submit to frequent ocular examination. It is surprising how well patients cooperate when told of the visual complications frequently associated with the disease and given an explanation of what may be in store for them.

Pathology

Friedenwald's great work³ showing that many of the tiny so-called round hemorrhages observed in diabetic retinopathy are in reality capillary aneurysms is a great advance in the understanding of diabetes. As research of this nature progresses, other discoveries equally astounding may in the next few years reveal clues to the avoidance of numerous obscure features of this perplexing disease.

The pathologic changes in the retina, which are usually bilateral, occur in the area between the upper and lower temporal vessels and the region surrounding the optic nerve head. Early numerous so-called small round deeply situated hemorrhages or hemorrhagic spots present themselves, and, in addition, there are usually small exudates.

¹President's address, read before the Florida Society of Ophthalmology and Otolaryngology, Hollywood, April 23, 1950.

These are accepted by most ophthalmologists as the characteristic lesion of the retina in diabetes mellitus, constituting diabetic retinopathy.

Friedenwald,³ in 1948, mentioned having previously shown that some of the small red spots observed ophthalmoscopically in cases of diabetic retinopathy are not petechial hemorrhages as they appear to be, but are actually small capillary aneurysms, which can be recognized as such in serial sections. He observed, however, that whether these aneurysms occur primarily as such without rupture of the capillary wall, or whether they begin as minute petechiae which are subsequently grown over by endothelium remains obscure, as does the relation of these aneurysms to the exudates and to the frank hemorrhages.

This author stated further:

Flat preparations of the retina in cases of diabetic retinitis show great numbers of capillary aneurysms. . . . These aneurysms always have both an afferent and an efferent connection, and are, therefore, true aneurysmal dilatations, not endothelialized petechiae which would be connected to the vascular tree by a single channel. In some capillaries tiny knuckles can be seen in the walls, possibly representing the first stage of aneurysm formation. The aneurysms are most frequent in the central retinal region but occasionally can be found even quite far out in the periphery.

Very commonly there is a cluster of exudates in the retina surrounding the aneurysms. . . . These exudates usually lie in the outer fibrillar layer while the aneurysms are usually in the inner nuclear layer, but they surround the aneurysms so frequently as to suggest that they are formed by leakage of plasma from the aneurysmal wall. Frequently also there are frank hemorrhages in the tissue adjacent to the aneurysms. . . . I do not wish to imply that hemorrhages and exudates in these cases arise only from the aneurysms, but merely that the majority do arise in this fashion.

Similar capillary aneurysms are occasionally seen in cases of retinal vascular disease in nondiabetics, but they are quite rare and when they occur we have, so far, found not more than two or three of them in a whole retina. In the diabetic retinopathy the aneurysms are regularly present by dozens, sometimes by hundreds, and their pattern with the surrounding exudates and hemorrhages appears, so far, to provide a characteristic picture.

Therapy

Rutin is still on the defensive as far as what it will do to help diabetic hemorrhages is concerned. So far, it seems to improve the capillary fragility but not the diabetic retinal lesions. Regarding the perplexing problem of treatment, Walker² observed: "The principle that early and physiologic control of the diabetes may avert later hopeless and disastrous complications is gaining wider recognition, while the thesis that crippling vascular damage is an inevitable concomitant of diabetes, regardless of the type of management, is being questioned with greater frequency." The ophthalmologist and the internist, working ever more closely together, will in time doubtless evolve some method whereby retinal complications can

be avoided and blindness from diabetes can be eliminated.

Analysis of Cases

As I began to go over my records covering a period of twenty-seven years in private practice, I was amazed to find any number of cases which could not be included in this study because I had failed to record the duration of the disease, the date on which the diagnosis of diabetes mellitus had been made and the time at which the retinal complications had begun. Approximately 30 cases had to be excluded. So it is obvious why I stress the importance of obtaining an accurate history in order that future records may help combat this disease which appears to be rapidly increasing. At the seminar on endocrinology held earlier this month in Miami Beach, Dr. Howard F. Root of the Harvard Medical School estimated that 3,500,000 Americans either are suffering from diabetes or will suffer from it during their lifetime.

In this series of 65 cases of diabetes mellitus from my private practice, the youngest patient was 4 and the oldest 86 years of age. The number of patients by age groups and the number in each group having retinal changes are shown in table 1. Retinal changes occurred in 36 of the 65 cases analyzed, with some loss of vision in one or both eyes occurring therefore in 55 per cent. In

Table 1.—Analysis by Age Groups

Age of Patient	Number of Cases	Cases of Retinal Changes
1 - 10	3	0
10 - 20	4	1
20 - 30	5	1
30 - 40	8	5
40 - 50	10	6
50 - 60	13	6
60 - 70	15	10
70 - 80	4	4
80 - 90	3	3
	65	36

table 2 the duration of the diabetes and the number of years elapsing before retinal changes were manifested are recorded for each case. This study indicates that the chance of the diabetic patient having diabetic retinopathy after fifteen years is 48.9 per cent and after twenty years, 60.0 per cent. It is noteworthy that in 1 case the patient had had diabetes for thirty-nine years without experiencing any retinal complications.

In 6 cases the vision in one eye was 20/100 or less. There were 8 cases in which the vision in both eyes was 20/100 or less. The vision was 20/50 or less in one eye in 9 cases, and in both eyes in 14 cases.

In his lecture at the Midwinter Seminar in Ophthalmology and Otolaryngology at Miami Beach last January, Dr. Arthur J. Bedell brought out a strange fact. In the majority of instances diabetic retinopathy occurs in well controlled cases

find himself badly mistaken. In 1 case of this series, for example, the patient, a young man aged 22, consulted me about getting married and inquired as to his chances for good vision later on. Dr. T. Z. Cason and I had first seen him at the age of 5 in a diabetic coma. He had now had diabetes for seventeen years, and his vision and visual fields were normal; but he wanted to know what to tell his future wife.

Table 2. — Duration of Diabetes Mellitus in Relation to Retinal Changes

Duration of Diabetes in Years	Number of Cases	Cases with Retinal Changes	Number of Years After Which Retinal Changes Occurred
39	1	0	0
29	1	1	24
27	1	1	20
25	1	1	15
24	2	2	12
			14
22	2	2	16
			18
20	3	1	16
19	1	1	10
18	2	1	16
17	1	0	0
16	3	3	12
			13
			14
15	5	3	10
			14
			15
14	3	3	7
			11
			13
13	4	1	5
12	5	4	9
			10
			11
			11
11	3	1	6
10	2	0	0
9	5	3	7
			7
			8
8	2	1	5
7	2	2	6
			5
6	2	0	0
5	2	1	4
4	3	2	2
			3
3	2	1	1
2	5	1	2
1	2	0	0
	65	36	

in which other complications are rarely observed and in which the sugar remains practically under control at all times.

Comment

If one is inclined to believe that the major portion of the public is not well informed about and on the alert for diabetes mellitus, he may

When I asked why he raised the question, he replied that he and some of his diabetic friends had read articles on diabetes in the various magazines and had noted the observation that after twenty years many diabetic patients began to lose their vision. My offer to give him statistics from many clinics that would tell the story did not satisfy him. He wanted to know from my records the averages in my own private practice, and hence this study was begun. He married, and so far there is no evidence of visual disturbance, but he submits to ocular examination now at intervals of six months.

Summary

If medical science continues to prolong the life of the diabetic patient, diabetes mellitus may top the list of major causes of loss of vision.

The duration of the diabetes rather than its severity appears to have more to do with the incidence of loss of vision than any other factor.

Friedenwald's outstanding work demonstrating that many of the pin point hemorrhages characteristic of diabetic retinopathy are actually capillary aneurysms marks a great advance.

It behooves the ophthalmologist to take the patient's history with particular care in cases of diabetic retinopathy, noting especially the time of onset of the diabetes or when it was first diagnosed as well as the time of the earliest manifestations of diabetic retinopathy, so that better statistics may be made available from a greater number of specialists.

Patients who have had diabetes mellitus for ten years or more should undergo ocular examination at regular and relatively frequent intervals, and the fundus of the eye should be carefully examined.

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Granuloma of the Larynx Following Intratracheal Anesthesia

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For nearly a quarter of a century after Elsberg's introduction of tracheal intubation for general anesthesia, first reported in the literature in 1910,¹ granuloma of the larynx following this procedure was given little, if any, consideration. The few reported cases and the infrequent references in textbooks attest the relative rarity of this lesion and also doubtless its infrequent recognition in association with this method of anesthesia, especially since it may occur surprisingly late. As New and Devine² recently observed, this anomaly is probably not as rare a sequela of intratracheal anesthesia as one would suppose.

Review of the Literature

In the course of preparing a thesis³ on this subject early in 1948, I found on reviewing the literature only 9 cases reported by eight authors. The first 3 cases were reported by British authors, Clausen⁴ in 1932, Gould⁵ in 1935 and Cohen⁶ in 1938; the other 6, appearing in the American literature, were reported by Smiley⁷ in 1940, Farrior⁸ in 1942, Kearney⁹ in 1946, Tuft and Ratner¹⁰ and also Barton¹¹ (2 cases) in 1947. My case appeared at that time to be the tenth one to be recorded. There have now come to my attention reports of other cases published in the interim between submission of my thesis and its publication in September 1949. In December 1947 McLaurin¹² reported 1 case, in September 1948 Finer¹³ and Hill¹⁴ each reported 1 case, and in June 1949 New and Devine² reported 9 cases. In order of date of publication, my case now appears to be the twenty-second rather than the tenth reported in the literature.

Incidence

In the 22 cases recorded through September 1949, 17 patients, or 77 per cent, were women, and 5, or 23 per cent, were men, a ratio of 3.4 to 1. It is of particular interest that in the series of 53 cases of contact ulcer granuloma reported by New and Devine,² observed in the period from

1937 through 1946 at the Mayo Clinic, there was in 9 a history of tracheal intubation prior to the onset of symptoms. In this group the ratio of women to men was 2 to 1. In the remaining 44 cases of indeterminate etiology all of the patients were men, and in this group reported in the literature these authors estimated the ratio of women to men at about 1 to 99. They regarded this striking contrast in sex incidence in the cases of intubation as probably due to the smaller larynx of women.

In 7 of their 9 cases the granuloma was bilateral, an occurrence noted in only 5 of the remaining 44 cases of their series in which there was no history of tracheal intubation. The growth occurred bilaterally in 12 of the 22 cases on record.^{2,3,9,10,12,14}

Site

The favored site appears to be the posterior portion of the vocal cord or on or near the vocal process of the arytenoid cartilage where the lesion is subject to trauma in the use of the voice. With the laryngeal mirror the ulcer in which the granuloma appears to originate may be viewed partly on edge in the region of the vocal process, and a tiny cuplike depression may be visible on one side in which the vocal process of the opposite side rests on phonation. Frequently, however, the actual ulcer is hidden by the exuberant granulation tissue present, and for this reason New and Devine² prefer the term "contact ulcer granuloma."

Pathology

Pathologically, chronic nonspecific inflammation characterizes the condition. There may be "polypoid masses composed of new granulation tissue richly supplied with blood vessels and covered with inflammatory exudate," or "small, hard, fibrous nodules composed of inflammatory fibrous tissue with few blood vessels, the whole covered with epithelium." Granulation tissue may surround the cartilage of the vocal process; the cartilage may be found in the floor of the

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ulcer, or it may be loose in the granuloma.²

Etiology

The cause is obviously mechanical. The intratracheal tube, either by pressure necrosis or by trauma, in all probability produces an ulcer of the larynx.² Smiley concluded that the larynx may react to trauma by the formation of an infectious granuloma such as is infrequently observed on the nasal septum. The consensus is that the tumor may generally originate in a traumatic ulcer of the cord exposing the superficial cartilaginous vocal process of the arytenoid; the granuloma which forms continues to grow while the ulcer meanwhile heals slowly from the periphery, producing a smaller and smaller base for the lesion with gradual formation of a pedicle.^{9,12,14}

Apparently neither the kind nor length of operation plays any particularly significant part. Certainly in the cases reported the kind of operation for which the intratracheal anesthesia was employed varied greatly, ranging from extraction of wisdom teeth¹ and tonsillectomy¹² to hysterectomy,⁵ cholecystectomy,⁹ gastrectomy¹⁰ and laminectomy.¹³ The duration of the period of intubation varied likewise. The shortest time reported was thirty-seven minutes² and the longest five hours,¹¹ except for Hill's case,¹⁴ in which a two stage lumbar dorsal splanchnicectomy required five hours for the first stage and four hours for the second stage.

Symptoms

The chief symptom is hoarseness, which varies in degree, frequency of occurrence, time of onset and period of duration. Other complaints are discomfort in the larynx, pain extending to the ear, and occasionally hemoptysis and chronic cough.² In 2 cases, dyspnea and cyanosis made an emergency operation necessary.^{5,9}

Treatment

Treatment consists of removal of the granuloma. The plan of treatment generally recommended consists of surgical excision of the tumor with removal of part of the vocal process if it is exposed, prohibition of irritant medication or swabbing, and absolute silence. New and Devine² stated: "In our practice the hypopharynx and larynx are cocaineized with 10% solution of cocaine and the patient is anesthetized with intravenously administered thiopental sodium (pentothal sodium), supplemented by curare (d-tubocurarine chloride). Suspension laryngoscopy is used to expose the larynx. The granuloma is re-

moved with cup forceps and the base of the wound is touched with surgical diathermy." They observed that surgical diathermy has been used for practically all of the patients treated at the Mayo Clinic for the last ten years with no ill effects noted. After a regimen of absolute silence for a month, they advised re-examination and observation at periodic intervals thereafter.

Recurrence of the granuloma is not infrequently encountered, necessitating repeated excision. These authors advocated waiting a month or more between operations, if possible, in order to give the ulcer a chance to heal without being stimulated by repeated intervention. They observed that if the granuloma bleeds readily when touched or is soft and friable when grasped with the cup forceps, there is often less chance of 1 operation sufficing than if it is hard and fibrosed. In 4 of their 9 cases 2 operations were necessary, and 3 operations were required in 1 case. Secondary removal was necessary also in the cases reported by Gould,³ Smiley,⁷ McLaurin¹² and Hill.¹⁴ The experience of McLaurin¹² and Hill¹⁴ with recurrence following removal of a sessile granuloma illustrates the importance of waiting for the tumor to become pedunculated before operating, provided the airway remains adequate. Ultimately, recovery is usually complete.

Review of Case

Since the case that came under my care has previously been reported,³ I shall review it only briefly here.

Thyroidectomy for thyrotoxicosis was performed on Mrs. L. G., aged 32, on April 29, 1947. An anesthesiologist administered pentothal sodium with curare intravenously and nitrous oxide and oxygen intratracheally. He reported the larynx normal preoperatively and he encountered no difficulty on introducing a Magill-Foregger tube, size 35, under direct vision using a laryngoscope. The intratracheal anesthesia was continued for one hour and forty minutes. On inspection when the anesthesia was discontinued and when the intratracheal tube was removed, the anesthesiologist noted no gross trauma of the larynx or cords, but observed a small amount of blood-tinged mucus in the larynx.

Two hours later the patient coughed up a sizable blood-tinged mucoid plug. She complained for four days of a severe sore throat and a distressing dry paroxysmal cough brought on by any attempt at talking, but there was no hoarseness. There were no symptoms referable to the throat or larynx when she was discharged from the hospital one week postoperatively.

Two weeks later, there developed a mild infection of the upper part of the respiratory tract, which subsided within a week. Because hoarseness, the chief symptom at this time, grew progressively worse for two and a half months, the patient was referred to me for laryngeal examination on July 22.

Indirect laryngoscopy revealed that a reddish polypoid-appearing mass obscured from view the posterior two thirds of the left vocal cord and also the posterior one third of the right vocal cord. It seemed to be at-

tached to the left cord, although the point of attachment could not be visualized because of its size. The visible portions of both cords appeared to be entirely normal, movements of the cords were apparently unrestricted, and the laryngeal airway was considered adequate. There was complete aphonia.

A diagnosis of laryngeal polyp was made, complete voice rest was the only treatment prescribed, and at intervals of two weeks for a period of two months the larynx was examined. An internist examined the patient during this time, with negative results. A review of the literature disclosed 6 similar cases with a diagnosis of granuloma of the larynx following intratracheal anesthesia. The clinical diagnosis of my case was changed accordingly. The long period of observation was intentional because previous observers had noted that such a granuloma would in time become pedunculated and its removal at operation would thereby be facilitated.

On examination preoperatively, the tumor, now somewhat smaller, was attached by a definite pedicle to the left vocal cord in its posterior third. Attached to the right cord, now visible in its entirety, a small pedunculated tumor directly opposite the one on the left cord could be seen for the first time. It was about one-fourth as large and could be seen only when the patient attempted phonation, for during inspiration it extended subglottically by a thin pedicle.

The patient was hospitalized on September 14 with a diagnosis of granuloma of the larynx. Direct laryngoscopy was carried out the next day with the use of a combination of 2 per cent pontocaine hydrochloride for local anesthesia and pentothal sodium with curare for general anesthesia and for relaxation of the larynx. The larynx was exposed with an adult-size Haslinger laryngoscope. Except for the vocal cords, all structures were normal in appearance. With an angular laryngeal biting forceps, a pedunculated, gray, granular-appearing mass approximately 5 to 7 mm. in diameter was removed from the upper surface of the left vocal cord at the junction of its middle and posterior thirds. In like manner a similar lesion approximately 2 to 3 mm. in diameter was removed from a corresponding position on the right vocal cord. Care was taken to remove no normal cord. No bleeding was encountered. Following the removal of the tumors and their pedicles flush with the cords, the larynx appeared normal.

The patient was discharged from the hospital with a good voice on the day after the operation. There has been no evidence of recurrence.

The pathologic diagnosis, made by Dr. Lucien Y. Dyrenforth, was "nonspecific granulation tissue in a mucous membrane."

Discussion

The infrequent occurrence of granuloma of the larynx as one of the few untoward sequelae of intratracheal anesthesia is by no means an indictment of this most important form of anesthesia, which is used particularly for operations about the head and neck, for neurologic and numerous other operations and as an adjunct to inhalation anesthesia for intrathoracic operations. Indeed, many surgical procedures, especially in thoracic surgery, would not be possible without it. That this complication does, however, occur suggests that every patient experiencing persistent hoarseness after being subjected to intratracheal anesthesia, even though a considerable period of time has elapsed, should be examined with the possibility of granuloma of the larynx in

mind. The suggestion that the larynx be examined postoperatively and appropriate treatment applied to any abrasions in all cases in which this method of anesthesia is used may well be heeded.^{11,12,14}

There is a type of patient, Lundy¹⁵ observed, who cannot tolerate any trauma to the mucous membranes. He attributed complications following the use of the intratracheal tube more to trauma associated with its introduction than to the tube merely lying in the trachea for the period of the operation except when proper technic is not rigidly followed.

Recently, Donnelly, Grossman and Grem¹⁶ mentioned as factors influencing damage to the larynx: the degree of proficiency of the anesthesiologist in laryngoscopic procedures; the individual anatomic characteristics of the patient, such as a short neck, which may affect the ease of intubation; the degree of relaxation and rapidity with which intubation must be effected; the metal laryngoscope; the diameter, shape and consistency of the intratracheal tube; and the duration of intubation. Certainly, gentleness during intubation may well be stressed as the watchword.

In my case, the role of the respiratory infection occurring three weeks postoperatively is problematic. It may have been the precipitating factor; or it may have been merely contributory, or even noncontributory, to a pathologic process already advancing. This case illustrates the characteristic symptom of hoarseness, the frequent bilateral occurrence of the lesion, and especially the importance of waiting for the tumor to become pedunculated before removing it, if the airway is adequate. When a sessile granuloma is removed, the raw area remaining appears to invite recurrence.^{12,14}

Summary

Granuloma of the larynx following intratracheal anesthesia doubtless occurs less rarely than the few reported cases would indicate. Surgeons should be aware of this possible complication, and when a patient, particularly a woman, complains of hoarseness, its outstanding symptom, or loss of voice, laryngeal pain or discomfort in the throat after tracheal intubation, the larynx should be examined with this sequela in mind.

This tumor appears to originate in a traumatic ulcer of the vocal cord, exposing the superficial cartilaginous vocal process of the arytenoid. If the laryngeal airway is adequate, waiting until

the granuloma has become pedunculated facilitates its removal.

The lesion frequently occurs bilaterally, as in the case which came under my observation.

Through gentleness during intubation, careful examination of the larynx preoperatively and postoperatively, and appropriate treatment of any abrasions, every effort should be made to avoid this complication. Also, alertness for its late appearance should expedite recognition of this infrequent sequela of an invaluable method of anesthesia.

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6n Propyl Thiouracil in Thyrotoxicosis Complicating Pregnancy

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The case herein described is being reported because it demonstrates a rational and safe method of therapy and management of thyrotoxicosis complicating pregnancy, by use of a thiouracil derivative. In our hands, 6n propyl thiouracil, given during the last four months of pregnancy, proved to be without any fetal or maternal morbidity.

Report of Case

The patient was a 27 year old white woman who had her last menstrual period July 27, 1947. Six weeks later, nausea and vomiting occurred. Because of the onset of nervousness, irritability and agitation, on December 17 she was referred for medical examination by her obstetrician.

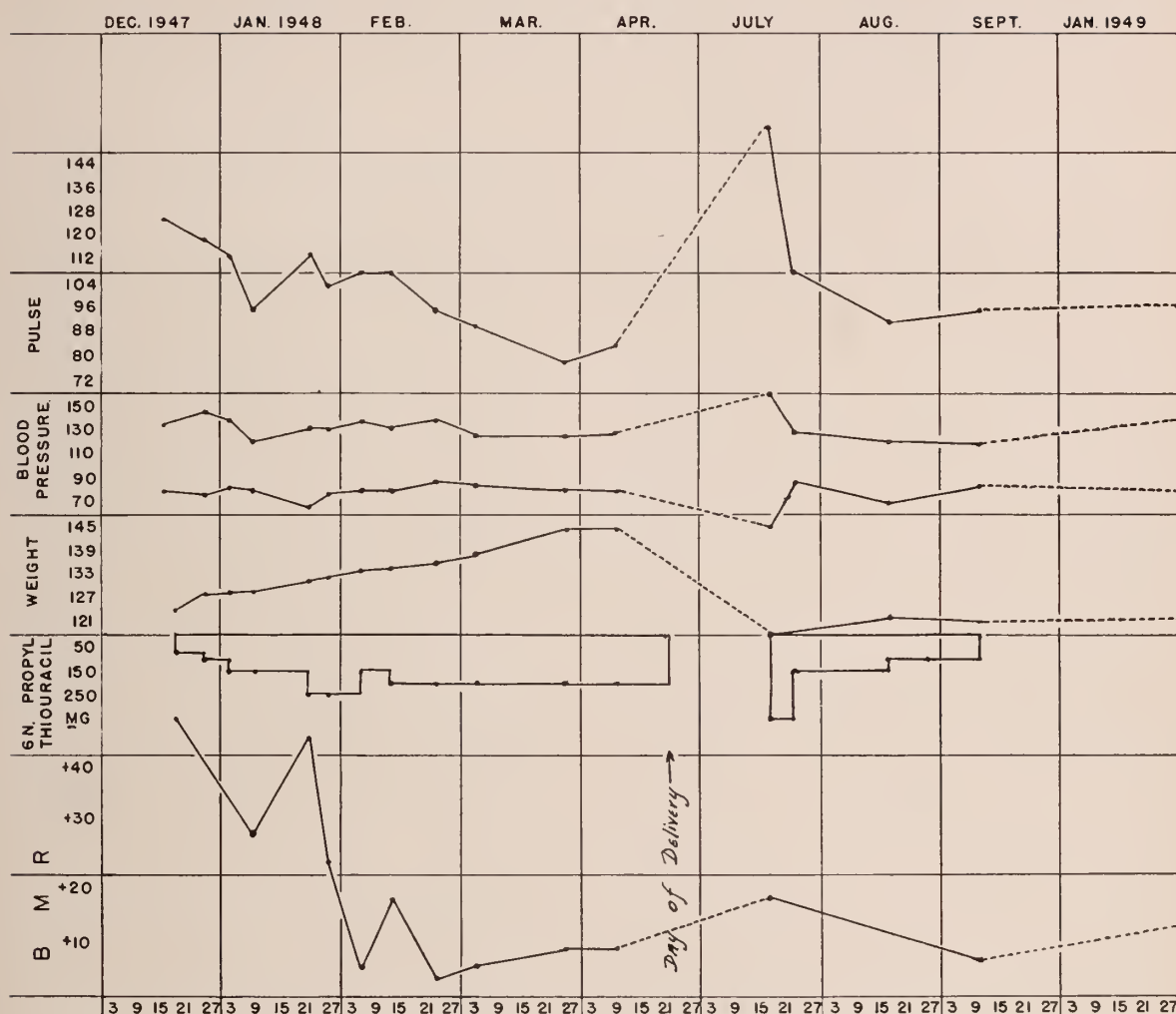
The salient features of the history included the facts that this was a first pregnancy and that the patient had previously displayed the symptoms of nervousness, irritability and agitation, which were diagnosed, after study, as due to hyperthyroidism and for which a thyroidectomy was performed in a New York hospital in January 1943. Following thyroidectomy, there was complete subsidence of symptoms until the present pregnancy.

On examination, the patient appeared apprehensive, mildly agitated and flushed. Her weight was 121 pounds. There was slight exophthalmos, but no lid lag, stare or

other abnormality. A well healed thyroidectomy scar was visible. The right lobe of the thyroid gland was palpably enlarged without evidence of nodules. The pulse rate was 120 and regular. Blood pressure was 132 systolic and 80 diastolic. The heart sounds were pounding, but no murmurs or adventitious sounds were audible. The extended hands presented a mild tremor. There was no dermatographia. There was moderate sweating of the hands. Urinalysis gave negative results, and the blood count was normal. The basal metabolic rate on several successive occasions was plus 46. This and all subsequent metabolic levels were determined at least twice each and were carefully studied and considered as to accuracy.

A diagnosis of thyrotoxicosis complicating pregnancy was made. On December 19, treatment with 6n propyl thiouracil, 25 mg. three times daily, was started (chart 1). At this time, the pulse rate was 126, and blood pressure was 132 systolic and 80 diastolic. The weight was 124 pounds. A week later, the pulse rate was 120, blood pressure 144 systolic and 78 diastolic, and weight 128 pounds; the drug was increased to four doses a day. On January 2, 1948, the pulse rate was 114, blood pressure 138 systolic and 82 diastolic, and weight 129 pounds; the dose was increased to 50 mg. three times daily. Six days later, on January 8, the pulse rate was 96, blood pressure 120 systolic and 80 diastolic, weight 128 pounds, and basal metabolic rate plus 27. The same dosage was maintained. On January 22, fourteen days later, the pulse rate was 114, blood pressure 130 systolic and 68 diastolic, weight

Chart 1. Results of therapy with 6n propyl thiouracil.



131 pounds and basal metabolic rate plus 43. Because of failure adequately to control the symptoms, 6n propyl thiouracil was given in doses of 50 mg. every four hours for five doses daily, so that the total daily dose was 250 mg. By January 27, the basal metabolic rate was plus 22, and on February 5, with the pulse rate 108, blood pressure 134 systolic and 80 diastolic, weight 134 pounds and metabolic rate plus 5, the dose was reduced to 50 mg. three times daily (total 150 mg.). On February 13, the only significant change was a rise in the basal metabolic rate to plus 16, and a fourth daily dose was added to make the total intake 200 mg. daily. This dosage was maintained until April 22. By this time the pulse rate had fallen to 84, the blood pressure was 126 systolic and 80 diastolic, and the basal metabolic rate varied between plus 3 and plus 8.

On April 22, the patient gave birth to a full term normal girl, two hundred and seventy days after her last menstrual period.

The patient was next seen on July 17, at which time the weight was 118 pounds, pulse rate 146 and blood pressure 160 systolic and 60 diastolic. She had taken no medication since April. She was given 350 mg. of 6n propyl thiouracil. On July 23, the weight was 120½ pounds, blood pressure 126 systolic and 88 diastolic, and pulse rate 108. The 6n propyl thiouracil was decreased to 150 mg. daily.

She then went to New York, where she was seen on August 17 by Dr. Aaron Hyman, to whom we are indebted for the follow-up reports on mother and daughter. At that time the weight was 121½ pounds, blood pressure 120 systolic and 70 diastolic, and pulse rate 92. Physical findings were negative, and the dose of 6n propyl thiouracil was decreased to 100 mg. a day. On September 10, the weight was 122 pounds, blood pressure 118 systolic and 84 diastolic, pulse rate 96 and basal metabolic rate plus 6. The 6n propyl thiouracil was discontinued. Final check on this patient was made February 1, 1949, at which time the weight was 122 pounds, blood pressure 138 systolic and 80 diastolic, pulse rate 94 and basal metabolic rate plus 12. She has been without 6n propyl thiouracil for four and a half months.

The infant has shown no evidence of either hyperfunction or hypofunction of the thyroid gland. No basal metabolic rates or other laboratory data, however, are available on her. During the entire seven months of observation, the infant has presented no clinical signs of cretinism or thyrotoxicosis.

Discussion

Thyrotoxic symptoms complicating pregnancy are generally considered uncommon,^{1,2} and the opportunities for the use of antithyroid drugs in

pregnancy are few.^{3,4} Early reports⁵⁻⁸ on thiouracil and its derivatives mentioned no cases of the two conditions coexisting. Later, several reports warned of dangers to mother and fetus, of the development of hyperthyroidism or hypothyroidism or heart failure.⁹⁻¹⁵

In December 1947, Bain¹⁶ reported the use of 6n propyl thiouracil for two months prior to term, both mother and infant withstanding delivery. The mother, however, required digitalization because of cardiac failure. Sexton,¹⁷ in 1946, reported 44 cases of hyperthyroidism treated with thiouracil. In 2, pregnancy was a complication. Details of the course in these cases are lacking, though in each the child was carried to term successfully.

In the case herein reported 6n propyl thiouracil was administered for over four months without mishap to mother or infant, either to the thyroid or heart.¹⁸ Thyroid surgery was not required either during pregnancy or in the postpartum period. During pregnancy, the basal metabolic rate was kept on the positive side because of the slightly elevated metabolic rate in normal pregnancies, and to avoid the danger of hypothyroidism in the newborn infant.

Summary

A case is reported in which thyrotoxicosis complicating pregnancy was treated by 6n propyl thiouracil for the last four months of the pregnancy. The infant was carried to full term without complication for mother or child. No other case has been found in the literature in which

therapy with this drug was continued for so long a period without complication and without surgery. It is suggested that this simple means of care be tried in such cases.

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ABSTRACTS OF MEDICAL ARTICLES

EVALUATION OF LUMBAR SYMPATHECTOMY. By Robert M. Lee, M.D., F. F. Krauskoph, M.D., and George D. Lilly, M.D. *South. M. J.* 42:864-869 (Oct.) 1949.

In this paper the results of lumbar sympathectomy carried out in a hospital with an open staff during a ten year period are evaluated. The series of 72 cases studied represents all lumbar sympathectomies performed at the James M. Jackson Memorial Hospital in Miami from April 1, 1938 to June of 1948. Of this number, 62 were contacted by the authors. They discuss the results from both a clinical and a physiologic standpoint.

Observing that lumbar sympathectomy is a valuable adjunct in the treatment of peripheral vascular diseases of the lower extremities, they concluded that the best response occurs in those diseases in which there is an increase in the amount of sympathetic tone, and less in cases of vascular sclerosis. Many extremities have been salvaged by this procedure, they noted, and in the majority that could not be saved, successful amputation has been effected at a lower level; thus, sympathectomy, done completely, gives lasting, worth while results.

AN EVALUATION OF PROPHYLACTIC PENICILLIN ADMINISTRATION TO PARTURIENT WOMEN. William C. Keettel, M.D., Joseph W. Scott, M.D., and Everett D. Plass, M.D. *Am. J. Obst. & Gynec.* 58:335-344 (Aug.) 1949.

In this study of a control series of 430 patients and an experimental group of 465 patients delivered over a period of a year in the Department of Obstetrics and Gynecology of the State University of Iowa Hospitals, the results suggested that penicillin may be given profitably to any woman with intrapartum fever, prolonged labor, postpartum hemorrhage or difficult operative delivery. With the reduced cost and the ease of injecting large doses of penicillin in oil or combined with procaine, its prophylactic use may be justified in the opinion of the authors. They regarded it a more logical adjuvant to aseptic delivery room technic than other suggested prophylactic procedures, and their results indicated that it can be expected to reduce the incidence of puerperal infections, especially in women with complicated labors and deliveries. They concluded, however, that its value in gonorrheal prophylaxis in the infant and in reducing neonatal mortality is equivocal.



THE SURGICAL MANAGEMENT OF DUODENAL ULCER. By C. Larimore Perry, M.D., F.A.C.S.,* and James W. Merritt, Jr., M.D. *South. M. J.* 42:777-784 (Sept.) 1949.

The subject of duodenal ulcer, long considered a medical problem, is discussed from the viewpoint of etiology, indications for surgery, types of surgery, preparation for surgery, technic and results. While recognizing the complex and obscure etiology of peptic ulcer, the authors regard an attack upon the acid level as the most effective method of treatment either medical or surgical. In addition to the usual surgical indications for operative intervention they advocate surgical therapy of ulcer for those patients who so strongly abhor and detest their medical regimen that they are miserable. Their conclusion is that the most effective surgical treatment of duodenal ulcer is adequate subtotal gastrectomy, performed aseptically, restoring intestinal continuity by a partial (Hofmeister) terminolateral retrocolic short loop gastrojejunostomy, this surgery to be performed after adequate preoperative preparation.

*Deceased, July 6, 1949.

SEVERE TETANY WITH LARYNGOSPASM AND PROLONGED COMA FOLLOWING THYROIDECTOMY, REPORT OF A CASE. By Jonathan H. Wood, M.D., and Kenneth A. Morris, M.D. *South. Surgeon* 15:705-710 (Sept.) 1949.

A case of severe hypoparathyroidism following subtotal thyroidectomy is reported because of unusual features in both the onset of the condition and its subsequent course. Since management proved extremely difficult and only fairly satisfactory, the authors present a brief review of the problems encountered.

Factors worthy of comment included inability to arrive at a satisfactory explanation of the etiology; the presence of laryngospasm as the presenting symptom, totally without premonitory numbness, tingling, muscle cramps or spasm; inability to control the convulsions following tracheotomy with unusually large amounts of intravenous calcium; and the prolonged period of coma (seventy-two hours) without localizing neurologic signs and without the abatement of signs of tetany in spite of normal blood calcium levels.

The use of dihydrotachysterol (AT10) in treatment is discussed. The exacerbation of symptoms, accompanied by a definite drop in urinary calcium which was associated with menses, infections and emotional disturbances was a phenomenon indicating the necessity for close observation of the patient over an indefinite period of time and also education of the patient to a complete understanding of his condition and the importance of his close cooperation with his physician.



PRIMARY CARCINOMA OF LIVER, REPORT OF A CASE LIVING AND WELL 25 MONTHS AFTER LEFT HEPATECTOMY. By Clifford C. Woods, M.D., and John N. McClure, M.D. *South. Surgeon* 15:238-240 (July) 1949.

With a plea for earlier diagnosis and more radical surgery, the authors report a case of primary liver cell carcinoma because the patient was alive and well more than twenty-five months following resection of the left lobe of the liver. In this case freedom from symptoms and the unusual longevity following complete left hepatectomy emphasize the value of early radical surgery, and the case points to a healthy trend in that direction.

HYPERPYREXIA DUE TO "DEMEROL." By M. Eugene Flipse, M. D., and M. Jay Flipse, M.D. South. M. J. 42:395-401 (May) 1949.

The authors present a case of prolonged and recurrent fever due to idiosyncrasy to "demerol." They found this type of reaction hitherto unreported in the literature.

In their case certain of the antihistaminics blocked this febrile response while other antihistaminics greatly potentiated the febrile response to "demerol." This definite evidence of an allergy made worse by some antihistaminics and benefited by others led the authors to suggest revision of the concept of the mechanism of action of these drugs, for if the mode of action were the same in all, namely, neutralizing histamine, they should produce an effect varying only in degree rather than opposite effects. They observed that if a patient's allergy is not benefited, or is aggravated by any one of the antihistaminics, it would be well to try each one of the available preparations before the possible value of antihistaminic therapy in any particular case is denied.



ARRHYTHMIAS IN NORMAL HEARTS. By David A. Nathan, M.D. South. M. J. 42:746-753 (Sept.) 1949.

In this study of 895 electrocardiograms disclosing many varieties of arrhythmias, with organic heart disease excluded from the series, the etiologic factors responsible for the aberrant rhythms were (1) psychogenic states; (2) acute infectious processes of extracardiac origin such as nasopharyngitis, septic tonsillitis and pneumonia; (3) toxic states resulting from alcohol, coffee, nicotine or drugs. In the majority of instances psychogenic factors were responsible for the arrhythmias.

Observing that arrhythmias in the normal heart approach those encountered in organic heart disease, the author emphasizes the importance of classifying correctly these abnormalities since limitation of activity need not be instituted for the majority of abnormal rhythms. He concluded that the prognosis is excellent, with longevity of life unaffected, in those patients without heart disease.

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Aims and Creed of American Medicine To Be Told

The decision of the Board of Trustees and the Campaign Coordinating Committee of the American Medical Association to launch a nationwide advertising program on behalf of American medicine may come as a surprise to some. On mature reflection and thought, however, the announcement should be welcomed.

The advertising campaign, which will be launched in October, carries a total budget of \$1,100,000, of which \$565,000 will be allocated to newspapers, \$300,000 to radio and \$250,000 to national magazines. The newspaper advertising schedule calls for blanket coverage of every bona fide daily and weekly newspaper in the United States, and of newspapers in Hawaii and Alaska as well. Space reservation in all papers will approximate 70 inches. About 30 of the leading magazines and many advertising trade publications will be included in the program, and approximately 300 radio stations will participate.

An announcement from the office of the American Medical Association's National Education Campaign states that the American Medical Association is embarking on this nationwide advertising program for two reasons: "First, it is determined to aid in every way possible in increasing the availability of good medical care to the American people through the medium of voluntary health insurance. In that respect, the advertising copy will be designed to make the American people 'health insurance conscious' and to encourage the extension and development of prepaid medical and hospital care as a means of taking the eco-

nomic shock out of illness. Second, American medicine is determined to alert the American people to the danger of socialized medicine and to the threatening trend toward state socialism in this country."

Such a campaign should relieve members of the medical profession of the necessity for continuing exhaustive campaigns and should bring the issue of government-controlled medicine squarely to a head. The campaign probably will crystallize public sentiment, strengthen confidence in the medical profession and serve as a reminder to the public that the profession has accomplished and can accomplish a great deal if it is not handicapped by government domination.

Nibbling at Freedom

When it became evident that the administration bill for nationalization of medicine with its enormous addition to the already unbalanced budget could not be expected to pass the present Congress, its proponents set out characteristically to nibble at freedom on the theory presumably that half a loaf is better than none. They announced that only parts of the plan for the welfare state would be attempted. This "foot in the door" technic is a nibbling process which is an all too familiar feature of the socialistic program of establishing a planned economy in a country accustomed to freedom of opportunity.

Take, for example, federal aid to education, including medical education. This part of the welfare program has strong appeal, for money is attractive to schools which find themselves in financial difficulties, and likewise to those not in

such straits. Proffers of easy administration are as dangerous to freedom of thought and action in medical education as are offers of easy living, observed a distinguished medical leader recently, and he warned that every subsidy carries with it the threat of regulation regardless of denials. With him we agree that "the marvelous progress of medicine must not be impeded by a socialistic program of the welfare state, blindly adopted by an administration as a political expedient to maintain itself and its associated bureaucracies in office."

The Baby Racket

There flared recently in Florida newspapers the not unfamiliar headline, "New York-Florida Baby Racket." Periodically, the news spotlight turns to black market placement of babies and thereby serves to emphasize not only the evil of this illicit traffic but also the value of a properly licensed child-placing agency, as mentioned editorially in *The Journal* in August 1948.

Physicians who use the services of licensed child-placing agencies hardly need special commendation, for that obviously would seem to be the wise course to pursue and the one expected of them. Independent, commercial and black market placements are not in keeping with the high ethical ideals on which the medical fraternity prides itself.

There are, however, physicians throughout the country — many of them reputable practitioners whose ethics otherwise are beyond reproach — who team up with obliging lawyers and easily-swayed, sentimental county judges to make it possible for almost any couple to obtain a baby — at a price. They offer real competition to operators of disreputable maternity homes. Some of these persons will stop at nothing to cut themselves in on a racket that nets hundreds of thousands of dollars a year.

Why do well meaning couples support a baby racket which taints the nation? They must realize the ever present danger of obtaining a child physically or mentally unsound. Too, outright blackmail, one of the great risks resulting when children are placed through irregular channels, is a common occurrence in the baby adoption picture.

Many times these would-be foster parents get tired of waiting for a baby promised by a bona fide adoption agency, not as aware as is the agency of the permanency of adoption and the tragic consequences that may ensue. The long period of

time that elapses between submittal of an adoption application and final placing of a child brings criticism on bona fide agencies. The chief reason, however, while some couples must wait for a year to several years for a child through legal channels is that "the supply of adoptable babies is being raided daily by unscrupulous operators of spurious maternity homes — and by unscrupulous doctors and lawyers."

Physicians of this state are privileged to have the Children's Home Society of Florida with which to cooperate. Under its license from the State Welfare Board, the Society is obligated to conduct its services under the rules, regulations, standards and policies of the Welfare Board, which are practically the same as those of the Child Welfare League of America, of which the Society is a charter member agency. Many members of the Florida Medical Association are strategically situated to promote the activities of this legitimate agency by channeling adoptive babies to waiting couples through its services, thereby decreasing the period of waiting in proportion as the irregular traffic in babies is reduced and at the same time giving maximum protection to all concerned.

'The Soviet of Washington'

The tragedy of today is that we are selling our freedom and do not know it. So remarked a Florida physician recently, and apparently all too truly. Any teen age student of American history knows that the greatness of this country at the present time is the cumulative product of individual initiative. Are we selling out for the gold brick of socialism? How far have the inroads of foreign ideologies and subversive elements penetrated?

The state of Washington appears to afford an excellent example and also a warning. As far back as 1936, James Farley is said to have referred to 'the 47 states and the soviet of Washington.' Today, that state's old age pension and general assistance law is condemned by Republican Governor Arthur B. Langlie in a recent interview as a calculated communist attempt to wreck the state financially and morally.

Washington's plan embodies all the "free" medical services of British socialism. The pension scheme will cost 206 million for the 1949-1950 biennial and is giving the state a 36 million annual deficit. Not only does it hand out generous checks to 185,000 dolers, but it also gives them

all free medical, dental and hospital care, including prescriptions, glasses, hearing aids and artificial limbs. These latter provisions, patterned after British socialized medicine, are dispensed alone by Washington among all the 48 states.

Governor Langlie both preceded and succeeded in office former Democratic Governor Mon C. Wallgren, President Truman's intimate, whom the President appointed to the Federal Power Commission last year after his nomination of his old Senate crony to the National Security Resources Board was rejected by the Senate. In 1945, when Wallgren succeeded Langlie, the state had a \$72,-000,000 surplus. When Langlie returned to office four years later, the surplus was reduced to \$32,-000,000 in the face of increased revenues during the Wallgren administration, and in addition he received from Wallgren a \$206,000,000 social security bill for 1949-1950, which could only mean a tremendous deficit.

It all adds up — to a warning, it would seem, which should not be ignored.

The Heart and Soul of Medicine

Warning the American Urological Association not to neglect religion, Dr. Carl Rusche, out-going president, commented at the annual meeting in June: "In the pursuit of scientific wizardry we may have lost some the heart and soul of our profession."

This opinion doubtless is shared by many physicians, in particular Dr. John Rankin MacElroy of Jonesville, N. Y. Chosen New York's outstanding general practitioner for the year 1949, Dr. MacElroy expressed concern about what type of medical service would be available to his friends and patients when he could no longer serve them. Too, what of the reluctance and oftentimes the refusal of recent graduates with ample intern and residency training to undertake practice in small or rural communities?

A source of particular concern was "the results of the latter-day methods of determining fitness for entrance to medical schools, methods that seem to overlook entirely the fact that, as long as medicine, agriculture, and industry shall endure, there must be laborers in the field to carry out the findings of scientific research, or that the rough plank in the stable floor often serves a more useful purpose than when polished and laid in a ballroom." Forgetting the A's and B's in the premedical courses, Dr. MacElroy would inquire more deeply

into the character, the courage, the resourcefulness, the aspirations and the aims of the candidate. Then he would "get him out in practice before years of internship and residency have placed him in the same category as the overtrained bird dog who blinks his birds."

Out of fifty-six years' experience in medical practice, this beloved general practitioner speaks with conviction on medicine's present battle for its freedom. His message merits the consideration of every member of the profession:

I am concerned, even as you are, over the threat of a nation-wide infection that strikes at the roots, not only of medicine, but of agriculture and industry and everything that is "America the Free." An infection that to my mind is parasitic in origin, arising in the jungles of the sob sisters, the parlor pinks, and the do-gooders, activated by the gas bacillus of power-seeking politicians. An infection that I feel cannot be treated successfully by the barbiturates of prepaid hospital and medical insurance and the psychosomatic therapy of argument and persuasion, an infection that needs the intensive, deep therapy of better distribution of qualified physicians throughout all communities, men or women of determination who are ready, willing, and able to make themselves an integral part of the economic, social, and fraternal life of the community, with courage and self-confidence, the ability to meet emergencies with calmness, and that indescribable something that inspires confidence; who realize that neither illness nor accident recognizes Thursday and Sunday off; who are willing to drive a Ford instead of a Cadillac for a few years. Men and women who will again bring to the front that relic of bygone days, "The Art of Medicine," and use it in their application of the scientific advances of recent years. Then the physician will recover his rightful place in the sun of public opinion, unobscured by the mirage of his workshop.

It occurs to us, as it did to the editor of the New York State Journal of Medicine, that what Dr. MacElroy says is worth many times the theoreticians' vain promises of something for nothing.¹

¹The Art of Medicine, editorial, New York State J. Med. 50:1465-1466 (June 15) 1950.

New Tuberculosis Sanatorium

Florida's new \$4,000,000 tuberculosis sanatorium, located at Lantana near West Palm Beach, was dedicated on July 16, 1950. It will serve tuberculous patients from the Southeast tuberculosis district. This 500 bed hospital will provide full medical and surgical care for the patients and is equipped for the latest known medical therapy.

The building is 795 feet long, constructed of concrete and steel and is fire-resistant. It is built in a straight line, since the latest hospital construction has proved that more patients can be served efficiently in a building of this type. Also, it requires less personnel. There are no wards,

and the largest patient room contains four beds.

The Lantana institution is the first of three new hospitals for tuberculous patients for which construction was authorized on a two year basis. Tampa will receive a 500 bed unit serving the Southwest area while Northwest Florida will be served by a 350 bed hospital to be constructed in Tallahassee. Temporary Army barrack facilities now in use in Marianna will be used as a convalescent center upon completion of the new Northwest Florida Sanatorium. Completion of these new hospitals will give Florida 1,725 beds for patients with active tuberculosis and 225 beds for convalescent patients.

Medical director for the sanatorium at Lantana is Dr. R. D. Thompson. He is well known in Florida, having served as medical director for the sanatorium at Orlando from 1938 to February 1949.

Annual Short Course Held

The Eighteenth Annual Graduate Short Course was held during the week of June 26, 1950 at the George Washington Hotel in Jacksonville. It was adjudged highly successful, the total registration reaching 203, a considerable increase over the attendance last year. Twelve residents attended, and the physicians of Jacksonville responded well with 106 registering. There were 12 Negro physicians in attendance.

For the first time, the pharmacists of the state were this year invited to attend as guests, and 16 availed themselves of the opportunity. The course included a series of lectures on pharmaceutical advances, presented under the direction of Dr. Perry A. Foote, Dean of the College of Pharmacy and Director of the Bureau of Professional Relations of the University of Florida. This review of the newer drugs and present pharmaceutical research was an innovation well received by both physicians and pharmacists.

Presented annually by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health, this course is arranged particularly for the benefit of the general practitioner, but is likewise of interest to specialists in the various branches of medicine included in the schedule. The Medical Postgraduate Course Committee is gratified at the increased attendance this year and welcomes constructive suggestions that will encourage better

attendance and promote improvement in the program for the week of graduate instruction next year.

Medical Postgraduate Course Committee
T. Z. Cason, M.D., Chairman

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Alford, Samuel J., Jr., Jacksonville
Burch, Reuben N., Jr., Miami
Cava, Edward E., Miami
Hutchinson, Robert H., Tallahassee
Keiber, Henry F., Winter Haven
Leon, Andrew J., Miami Beach
Terheyden, Wm. A., Jr., Miami Beach
Thomas, Merrick D., Jr., Miami
Thompson, J. Q. U., Jacksonville

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Rene A. Torrado of Miami Beach announce the birth of a daughter.

Dr. and Mrs. Bert W. Malone of Jacksonville announce the birth of a daughter on May 24.

Marriages

Dr. Edward F. Fox and Miss Virginia Orr, both of Miami Beach, were recently married.

Deaths — Members

Johnston, Geo. C., Orlando	May 29, 1950
Carlton, Leland F., Tampa	June 5, 1950
Swift, Edwin C., Jacksonville	June 5, 1950
Potter, G. Walter, St. Augustine	June 8, 1950

Deaths — Other Doctors

Tatum, P. A., Columbus, Ga.	April 2, 1950
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PHYSICIAN WITH TRAINING and experience in allergy seeks location in Florida for practice. Association with group or other physician desired. Write 69-36, P. O. Box 1018, Jacksonville, Fla.

PEDIATRICIAN DESIRES ASSOCIATION: With physician having established practice in pediatrics. F.A. A.P., M.D. 1928. Pediatrics only since 1938. Four-year residency in pediatrics at Long Island College of Medicine. Write 69-38, P. O. Box 1018, Jacksonville, Florida.

FOR SALE: Well established Pediatric practice, Central Florida. For details, write 69-37, P. O. Box 1018, Jacksonville, Fla.

STATE NEWS ITEMS

Dr. John O. Rao of Kissimmee left recently for an extended trip to Europe. While away he will attend the International Cancer Congress in Paris.

Dr. Howard W. Reed of Gainesville, director of the University of Florida's Student Health Service, was named a member of the National College Association's Committee on Administration.

Association members who attended the national convention of urologists in Washington, D. C. recently were: Drs. John R. Browning and Jerome H. Newman of Jacksonville; A. Fred Turner, Joseph C. Hayward and Louis M. Orr, II, of Orlando; Albert A. Parrish and Eugene C. Chamberlain of Fort Lauderdale; Kenneth E. Montgomery of West Palm Beach; Frank M. Woods and James J. Nugent of Miami; Howard H. Curd of St. Petersburg, and James L. Estes and Linus W. Hewit of Tampa.

Dr. A. M. C. Jobson of Tampa was elected president of the Tampa Lions Club for the ensuing year.

Drs. Morton M. Halpern and Lawrence Adler of Miami recently conducted a forum on cancer at a meeting of Sholem Lodge, B'nai B'rith in Miami.

Drs. J. Randolph and Jean J. Perdue of Miami and Miami Beach are on an extended tour of the European countries where they plan to visit leading medical institutions.

Dr. H. Marshall Taylor, Jacksonville, was the guest speaker at the Fulton County Medical Society Meeting in Atlanta, Georgia, on June 5. Dr. Taylor's address was on "Hygiene." Some 200 doctors were in attendance.

Drs. Joseph W. Taylor and Joshua C. Dickinson left early in July for a trip to Europe.

Dr. Taylor will attend the International Congress of Ophthalmology in London and Paris. Dr. Dickinson will attend the International Congress of Radiology in London and the International Congress of Cancer in Paris.

Dr. Wallace H. Mitchell of Key West has accepted an assistant residency in obstetrics and gynecology at the University Hospital in Baltimore, Maryland. He will assume his duties on July 1, 1950.

Dr. Mitchell hopes to resume his practice in Florida at a later date.

Dr. Karl B. Hanson has returned to his practice in Jacksonville following a trip to Philadelphia where he attended several medical clinics.

Dr. Chadbourne A. Andrews, Tampa, has been appointed a member of the Council of the Southern Medical Association from Florida for a regular Council term of five years. Dr. Andrews succeeds Dr. William C. Thomas, Gainesville, whose term will expire with the close of the St. Louis meeting in November, and who, having served the constitutional limit, is not eligible for reappointment.

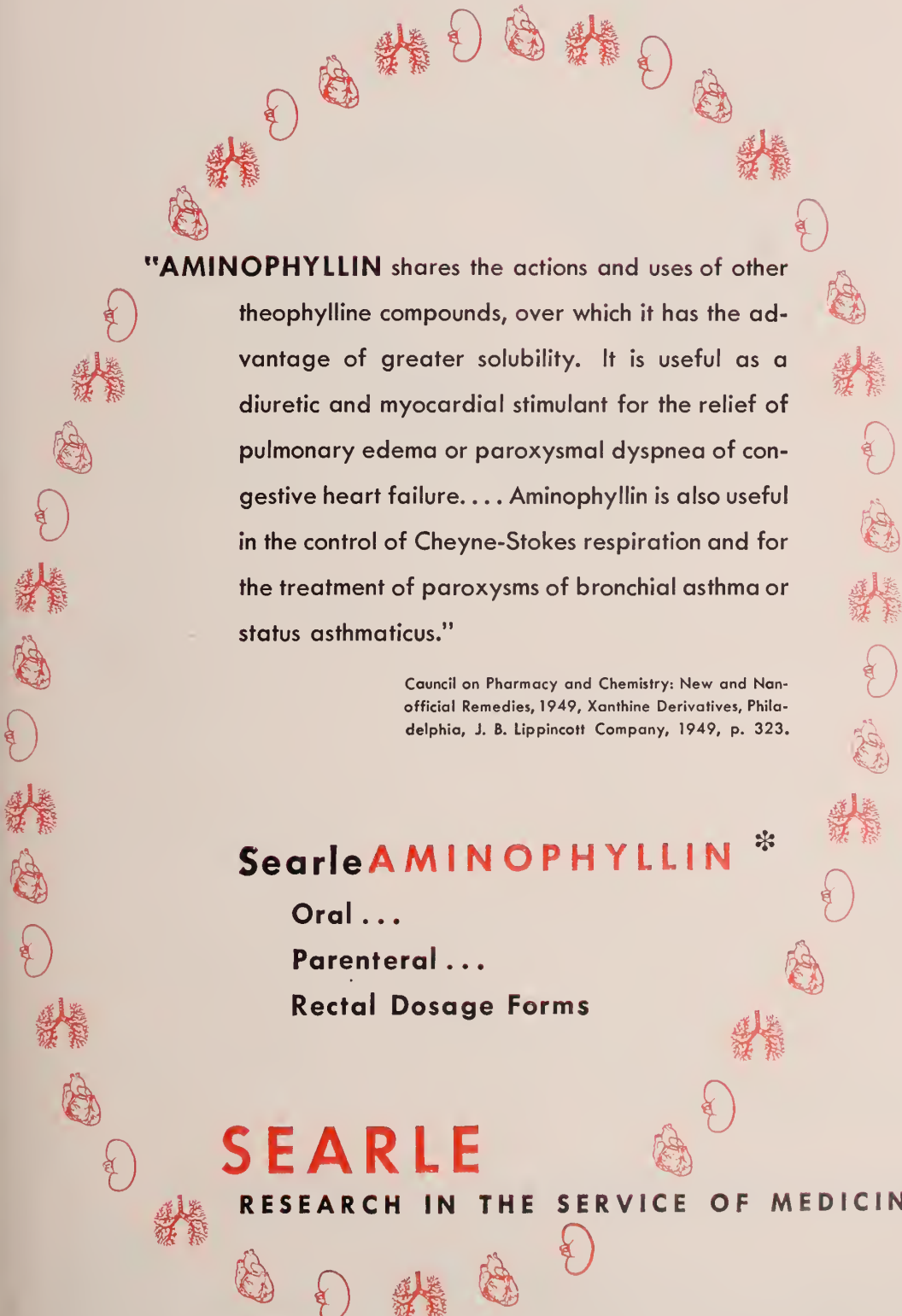
Dr. John T. Stage of Jacksonville was guest speaker at the graduation exercises of the Medical Assistants and Nursing School of Jacksonville.

Newly elected officers of the State Board of Medical Examiners are: Dr. William C. Thomas, Gainesville, president; Dr. Bricey M. Rhodes, Tallahassee, vice-president, and Dr. Homer L. Pearson, Jr., Miami, secretary.

Dr. Nathan S. Rubin of Pensacola is on an extended trip out of the country. Dr. Rubin will visit various medical centers on his trip and plans to return to his practice in early August.

Dr. Sullivan G. Bedell of Jacksonville has been named the president of the newly formed Child Guidance Clinic of Duval County.

Dr. James R. Nieder of Delray Beach was among the speakers at a recent meeting of the local Lions Club. Dr. Nieder explained the use of cortisone and similar drugs and discussed the progress being made in this field of medical research.



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Council on Pharmacy and Chemistry: New and Non-official Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

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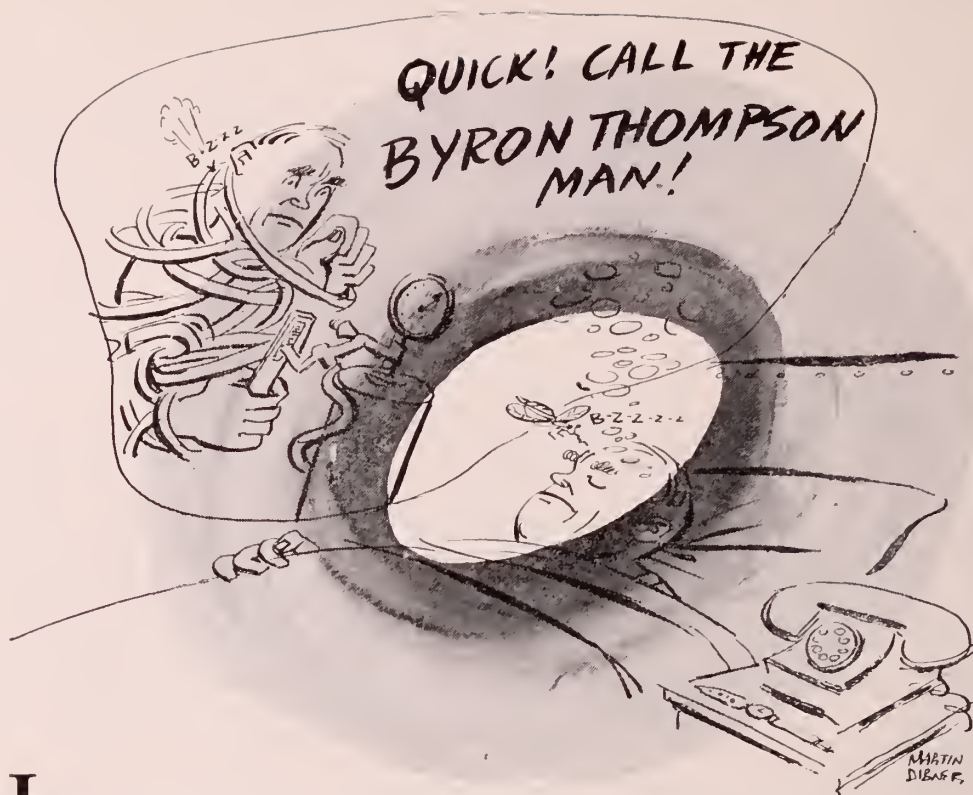
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Dr. Randall W. Snow has returned to his practice in Hollywood following a recent trip to Birmingham, Alabama, where he attended a nutrition clinic.

Dr. Paul W. Hughes of Ft. Lauderdale recently addressed the local Business and Professional Women's Club. He chose for his subject the effects of an atomic explosion.

Dr. Robert G. Head of Marianna recently conducted pre-school examinations for all children in Cottondale who will be starting to school next September.

Dr. Taylor W. Griffin of Quincy is in Chicago taking postgraduate work in gynecology at the Cook County Graduate School of Medicine.

Dr. Walter B. Clement of Punta Gorda recently spoke before the local Rotary Club on advances in medical science, particularly in reference to cancer.

COMPONENT SOCIETY NOTES

Dade

The Dade County Medical Association held its regular monthly meeting July 5. Heading the scientific program was a paper, "The Neuro-Hepatic Syndrome: A Common Fatigue State Simulating Psychoneurosis," by Dr. Bernard D. Ross. The paper was discussed by Drs. Donald F. Marion and Joseph W. Scott.

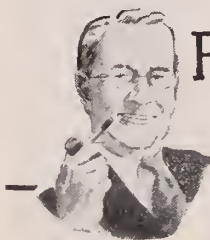
Duval

The Duval County Medical Society held a special meeting on Tuesday, July 11, for the election of new members.

Franklin-Gulf

At the regular monthly meeting of the Franklin-Gulf County Medical Society, guest speakers were a group of doctors from Thomasville, Georgia. Preceding the scientific session the doctors and guests enjoyed a seafood dinner. Members attending were Dr. Donald H. Anderson, Wewahitchka; Drs. Terry Bird, William P. Blackmon and James A. Steely, Apalachicola; and Dr. John W. Hendrix, Port St. Joe.

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From where I sit by Joe Marsh

Why "Moose" Changed His Mind

Last week, parents were calling Moose Jackson on the phone—and kids were hooting at him in the streets. All because Moose fenced in his field near the depot, where the kids play ball.

Moose got sore the way folks acted—and he refused to budge. Then Doc Sherman, who likes to play centerfield himself sometimes, decided to "use a little psychology."

Over a friendly glass of beer at Andy's Garden Tavern, Doc says, "Sorry this came up, Moose. We were thinking of asking you to umpire—what with your professional experience and all." (Moose used to play a little semi-pro ball way back.)

That did it! Next day Moose put up a stile over his fence. In return, the kids promised not to cause any damage. From where I sit, when you try to understand the other fellow's point of view—like his personal preference for beer or coffee—and take into consideration the will of the majority, why, things seem to go better all around.

Joe Marsh

simplify the
mother's
problem

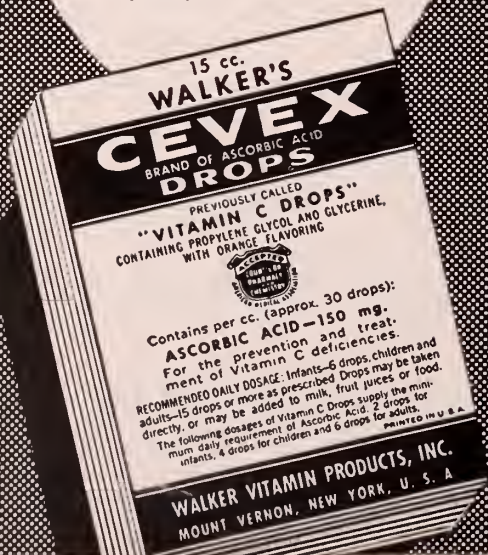
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Manatee

All members of the Manatee County Medical Society have paid state dues for 1950.

Marion

The Marion County Medical Society was host to the members of the Alachua County Medical Society at a joint meeting in Ocala on June 20.

Guest speaker for the evening was Rear Admiral John C. Adams, USN MC (retired). Dr. Adams, who now resides at Inverness, spoke to the combined group on naval aviation medicine.

Pasco-Hernando-Citrus

State dues for 1950 have been paid by all members of the Pasco-Hernando-Citrus County Medical Society.

Pinellas

With each new issue, the fledgling Picomeso Mail Bag of the Pinellas County Medical Society shows surprising growth. In addition to scientific presentations by members of the society, the Mail Bag contains guest contributions from the dental and nursing professions.

OBITUARY

George Coffin Johnston

Col. George C. Johnston of Orlando died of a heart attack on April 29, 1950 at Crescent City, Calif., while making a 20,000 mile tour of the states. He was 78 years of age.

The son of the Reverend George N. and Emma Coffin Johnston, Colonel Johnston was born in New Lisbon, Ohio, on April 4, 1872. After attending Washington and Jefferson College from 1888 to 1890 and Western University at Pittsburgh from 1890 to 1892, he enrolled in Western Pennsylvania Medical College at Pittsburgh, receiving the degree of Doctor of Medicine there in 1895. That same year he entered the practice of medicine in Pittsburgh, where he continued to practice for more than a quarter of a century, serving on the staffs of seven Pittsburgh hospitals.

Colonel Johnston was the first professor of roentgenology in the University of Pittsburgh. In 1909, he served the American Roentgen Ray Society as its president. Commissioned a major in 1917, he first conducted the X-ray School of the Surgeon General at Washington, D. C., and later

was in charge of the procurement of materials for field hospital equipment and the training of personnel for this roentgen service in the American Expeditionary Forces in France during World War I. At the close of the war, he returned to inactive duty with the rank of colonel.

In 1922, Colonel Johnston retired from the practice of medicine and moved from Pittsburgh to Orlando for his health. There he engaged in the retail automobile business and the operation of two investment companies. In 1927, he purchased the controlling interest in Radio Station WDBO, and he served as president of the Orlando Broadcasting Company and general manager of the radio station from that date until his death twenty-three years later.

A thirty-second degree Mason, Colonel Johnston was also a member of the Shrine and other Masonic bodies. He was a past president of the Orlando Chamber of Commerce and Rotary Club, the first president of the University Club and twice commander of the Orlando American Legion. He held membership in the First Presbyterian Church of Orlando.

Colonel Johnston was a member of the Orange County Medical Society and an honorary member of the Florida Medical Association and the American Medical Association.

His wife, the former Ida Davis of Pittsburgh, died in 1945, and their only child, Dorothy Davis Johnston, died in September 1949. Surviving are a brother, Rev. William W. Johnston of Los Angeles; and two sisters, Mrs. Evelyn Sehlbrede of Kirkwood, Mo., and Mrs. Gertrude J. Isett of Los Angeles.

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GYNECOLOGY—Intensive Course, Two Weeks, starting September 25. Vaginal Approach to Pelvic Surgery, One Week, starting September 18.

OBSTETRICS—Intensive Course, Two Weeks, starting September 11.

MEDICINE—Intensive General Course, Two Weeks, starting October 2. Gastro-enterology, Two Weeks, starting October 16. Gastroscopy, Two Weeks, starting September 11 and October 23. Electrocardiography & Heart Disease, Four Weeks, starting October 2.

DERMATOLOGY—Formal Course, Two Weeks, starting October 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting September 25. Cystoscopy, Ten Day Practical Course, every two weeks.

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What Every Doctor Should Know

This column appearing monthly in the Florida Medical Journal is in effect a feminine wail in a wilderness of medical fact. Certainly the chances for its message to be received, or often noted, is slim unless the doctor, in thumbing through the pages seeking information for himself, has some notion of why a page is devoted to the Woman's Auxiliary to the Florida Medical Association.

We must discount the obvious implication that it is only for the ladies. Certainly those who are aware of its existence seek it out and read it, if the doctor remembers to take it home. But, considering the law of averages in the human element we must admit that not many issues are faithfully carted back and forth. Therefore, a more significant purpose lies behind the page devoted to the Woman's Auxiliary.

We are attempting to eradicate the notion that this Auxiliary is an organization which operates off in the distance and is an organization to which some women belong, but for what reason every doctor isn't acquainted. We earnestly hope to make this organization a very personal and easily available advantage to every doctor and his wife in Florida. To the counties where an Auxiliary exists, we aspire to a 100 per cent membership. To the counties where none exists we aspire to a welcome from the wives of the medical groups, to organize.

The objects of this organization need no salesmanship, as the increase and size of its membership testify. Any group which bands together to foster good will, welcome the stranger, educate its mem-

bers, and work at assisting the men to whom they have already pledged loyalty, will attract the conscientious and idealistic person who is aware of its existence.

We are scouting the medical field now for those who have no opportunity to know us. In this field we are likened to the mustard seed, infinitesimal in importance to the doctor through whom his wife must hear of us, should he be of the opinion that his success is largely determined by his own activity, and thus discourages participation on the part of his wife. In this instance, we fall by the wayside.

To the doctor who is indifferent we fall on stony ground. The idea may appeal and sprout with interest for awhile, but will soon wither and die for it is lightly rooted. To the doctor who deploras women's organizations of any kind and considers them meddling and superfluous we fall among thorns which rise up and choke us. But, the doctor with vision who looks to the future, and there are many, is likened to good ground. They have and will bring forth good fruit.

At no time has this been so aptly proven as in the recent crisis when the faith of the doctor was rewarded by the indefatigable effort of the Woman's Auxiliary, who fought side by side to preserve a cherished freedom. This temporary conflagration lit up the field and revealed the importance of teamwork, but the day has passed when we can put down the "fire buckets" and disregard the incendiary notions directed toward the medical profession. In order not to retrogress we must progress.

We can no longer be isolated from the pattern of the developing trend. We must be well integrated before we can integrate beneficially and effectively in our respective communities.

We cannot share this unity and membership with a doctor's wife unless he dignifies it in her eyes with his interest and cooperation, because it is through him she becomes eligible. And, as in all endeavor, we are active in proportion to the pride we feel and the interest we have in protecting what our doctors represent.

Mrs. C. Robert DeArmas
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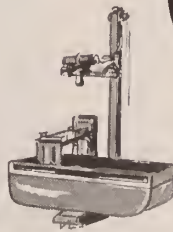
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Marianna, Oct. 30, 1950
B-Northeast	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	Ocala, Nov. 1, 1950
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Ft. Myers, Nov. 2, 1950
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	West Palm Beach, Nov. 3, '50
Florida Specialty Societies			
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	Hollywood, Apr. 22, '51
Anesthesiologists, Soc. of	Colquitt Pearson, Miami	Harold Carron, Tampa	" "
Chapter, Am. Acad. Gen. Prac.	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Genec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	V. Marklin Johnson, W. Palm Beach	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" "
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 11, '50
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	November, 1950
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, Nov 26-28, '50
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Cleveland, Dec. 5-8, '50
Southern Medical Association	Hamilton W. McKay, Charlotte, N.C.	Mr. C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James M. Crews, Memphis	Mr. L. H. Gunter, Montgomery	
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	June McCafferty, Mobile, Ala.	Mobile, Ala.

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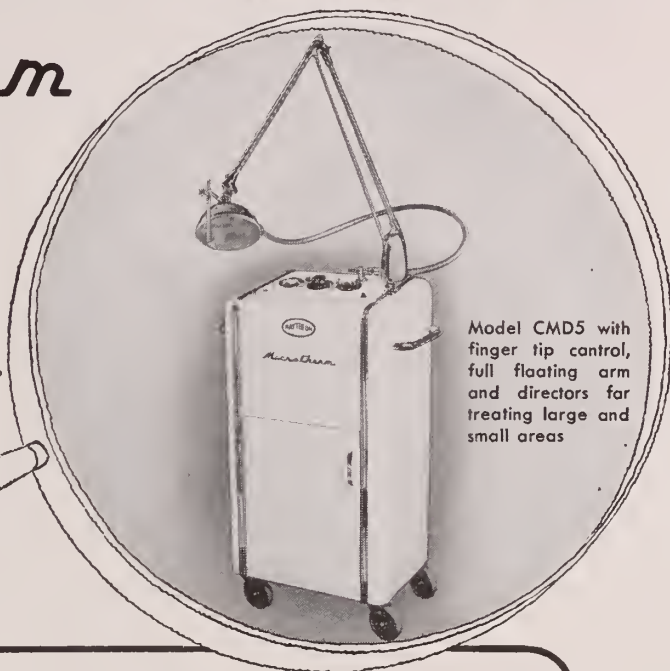
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					Total	Paid	
A	Bay	Daniel M. Adams, Jr., M.D. Box 593 Panama City	Jack Corbitt, M.D. Box 961 Panama City		17	16	A-1-52 Arthur J. Butt, Jr., M.D. Pensacola
	Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	68	
	Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
	Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	16	
	Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	16	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	47	44	
	Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		7	100%	
	Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	3	
	Taylor *Davie-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	212
B	Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 825 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	44	43	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
	Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	241	226	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	28	100%	
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McCane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	10	100%	
	St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
	Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	18	100%	
	Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	22	100%	
	Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	138	131	
	Seminole	Charles L. Park, M.D. 212 N. Park Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
	Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	59	54	593
C	Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	155	147	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	20	
	Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	100%	
	Pinellas	Albert R. Frederick, M.D. 408 Florida Power Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	171	169	
	Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	38	100%	
	DeSoto-Hardee- Highlands- Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	24	C-6-52 Leldon W. Martin, M.D. Sebring
	Lee-Charlotte- Collier-Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	26	24	
	Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	83	76	
	Indian River	Melton D. Council, M.D. Box 983 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	97	96	
D	St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	15	100%	
	Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	74	73	D-8-51 S. Marion Salley, M.D. Miami
	Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	537	460	
	Monroe	Herman K. Moore, M.D. 600 Elizabeth St. Key West	Allen S. Shepard, M.D. 403 Caroline St. Key West	2nd Thursday 8:00 P.M.	11	10	741

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Vol. XXXVII

SEPTEMBER, 1950

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IN THIS ISSUE

Cytologic Diagnosis of Malignant Disease
Nelson A. Murray



Chronic Pyuria in Infants and Children
Meredith Campbell



Medical News Writers Urged To Be Cautious
An Editorial



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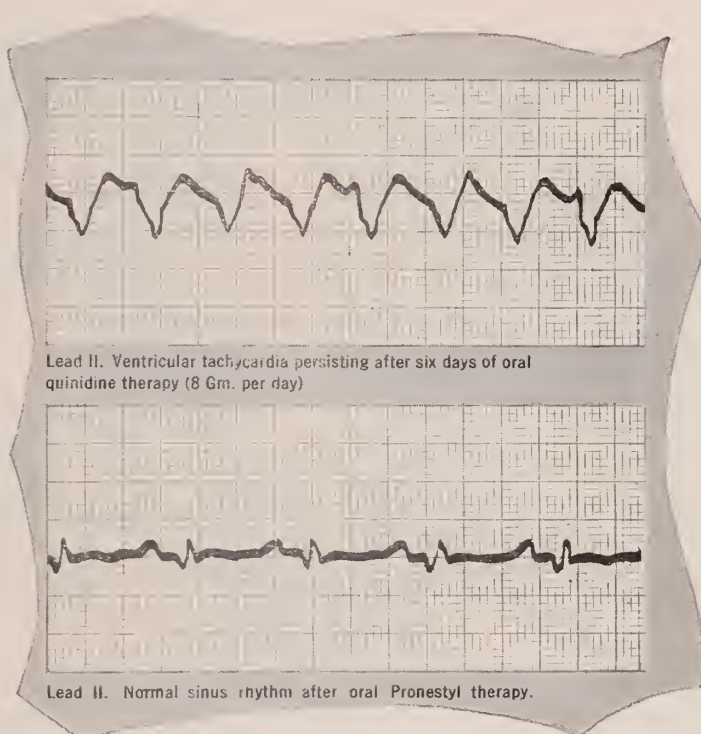
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- (1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., *Ann. Int. Med.* 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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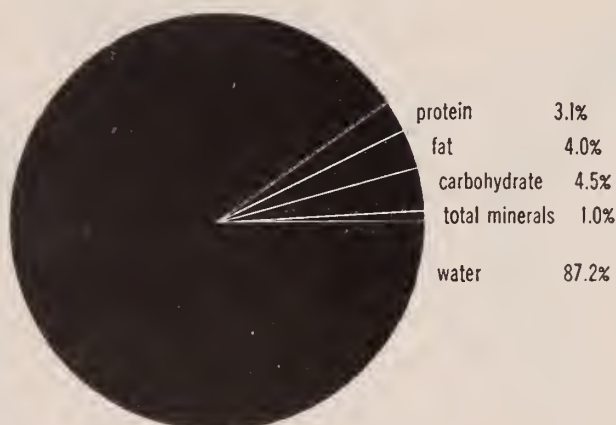
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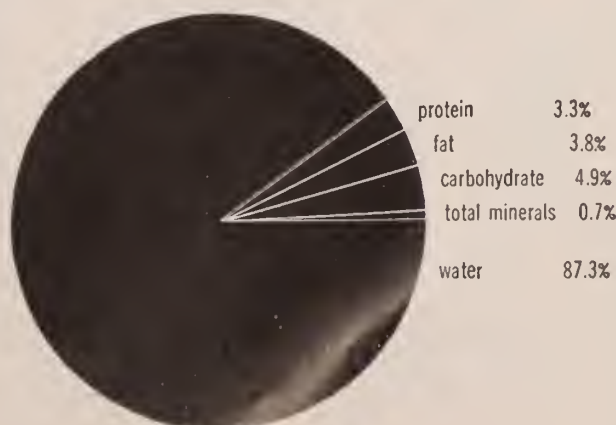
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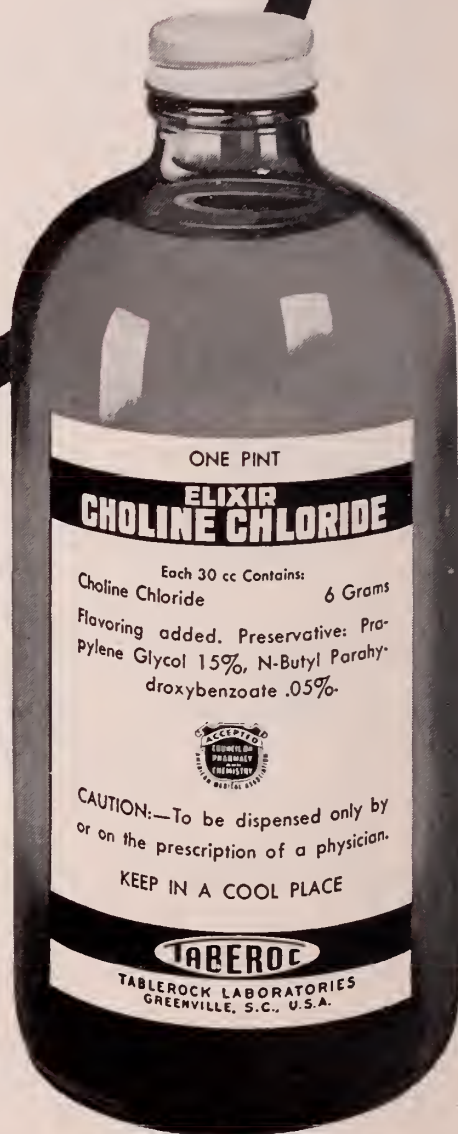
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1. Perloff, W. H.: Am. J. Obst. & Gynec. 58:684, 1949.

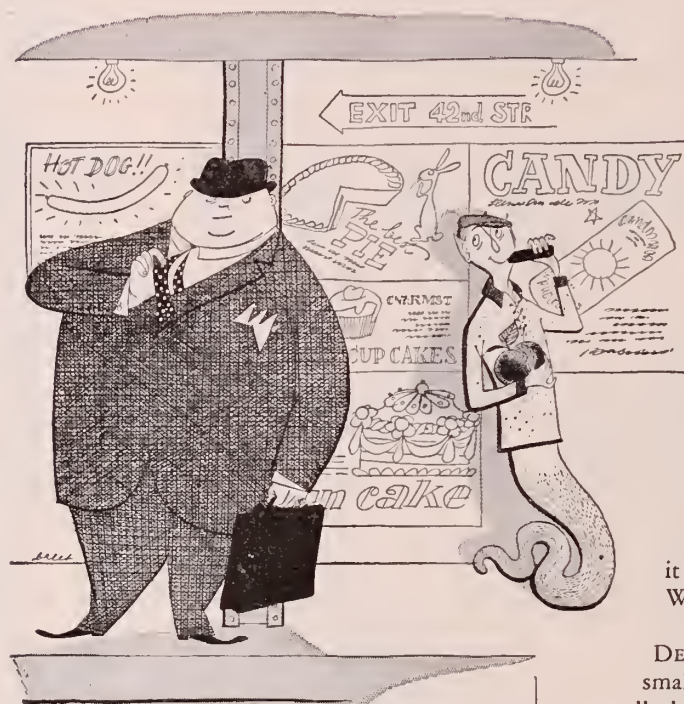
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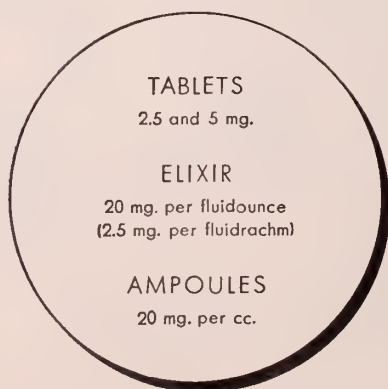
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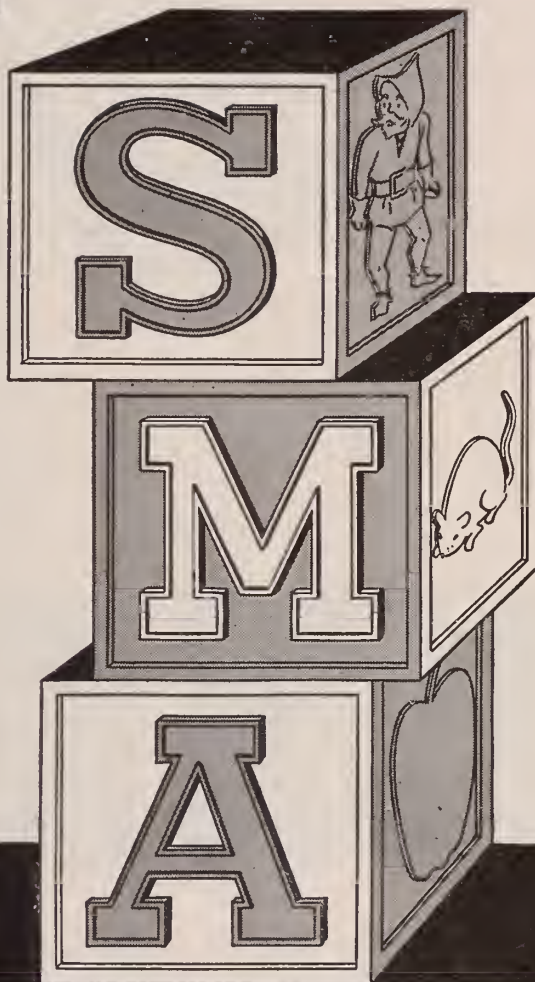


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**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60



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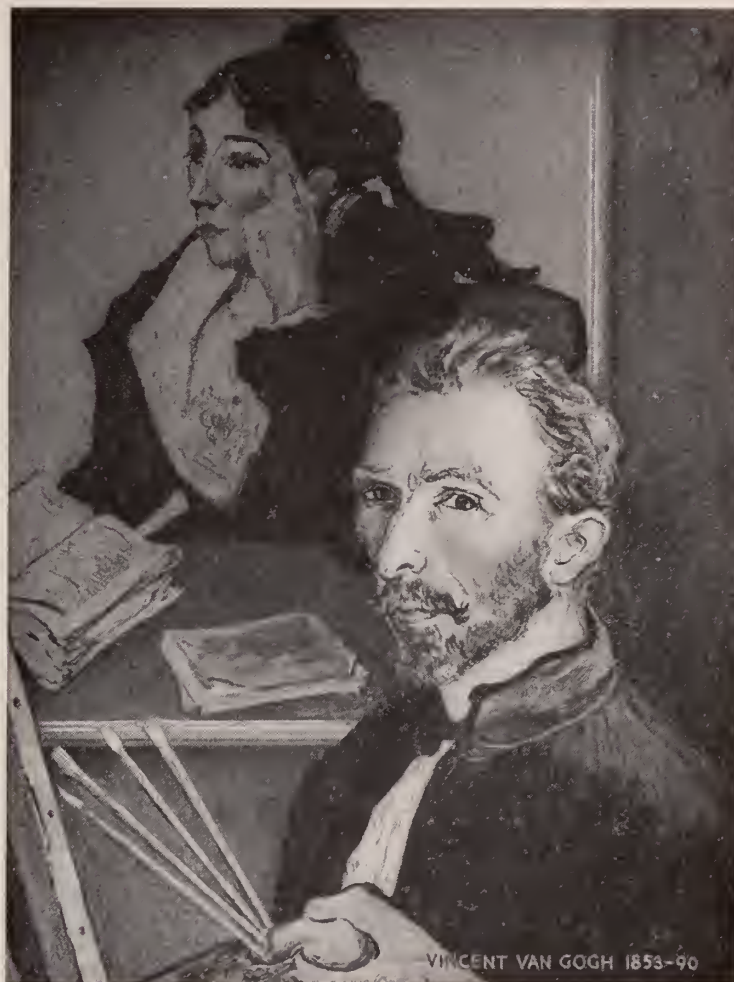
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Neo-Antergan Maleate is stocked by your local pharmacy in 25mg. and 50mg. tablets. Complete information concerning its clinical use will be sent on request.

¹Cooke, R. A.: *Allergy in Theory and Practice*, Philadelphia: W. B. Saunders Company, 1947, p. 186



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Cytologic Diagnosis of Malignant Disease

NELSON A. MURRAY, M.D.

JACKSONVILLE

Interest has been aroused anew during recent years in cytologic or "single cell" diagnosis of malignant disease. This interest has been largely stimulated by the lay press and popular magazines. Through these lay forces the public has been led to believe that the procedure is easy, quick and inexpensive, and, to a certain degree, infallible. Particularly has the female component of our population been led to believe that such an examination may be carried out by a physician in his office, or even by his office technician; after a quick vaginal smear and a glance through the magic microscope, the patient expects her doctor to tell her whether or not she has cancer. Boyd,¹ in referring to a popular magazine article on carcinoma of the cervix, quoted: "The new method is inexpensive, painless, and at least 97 per cent accurate. If put into general use, it may almost wipe out this form of cancer." As Boyd indicated, nothing could be farther from the truth. Such misinformation can result only in an untold amount of harm.

The cytologic or "single cell" diagnosis is nothing new and has been practiced by pathologists with varying degrees of success for many years. Although the new atlases and staining technics allow for beautiful color photographs, no new concepts have been added. One still must search for the characteristics of the malignant cell—the large, irregular, hyperchromatic nucleus, presence and size of the nucleolus, mitotic figures, change in nucleus-cytoplasm ratio and multinuclear cells. Since, however, these cell changes occur in non-neoplastic disease conditions, reliance on such criteria alone will lead to error. At the present time, there is no single criterion that will enable one to decide whether or not a given cell is malignant.²

While most attention has been directed to the female genital tract, one must realize that the source of material has little relationship to the value of the method. Sputum, gastric washings, pleural fluid, ascitic fluid, proctoscopic washings, urine, fluid from ureteral and renal catheterizations and bronchial washings may all be examined by this method. Of course one must be familiar with the picture of normal cells from the region in question and also with the neoplasms inherent to each particular location. In the examination of ascitic and pleural fluids one must constantly be on guard against interpreting endothelial cells as malignant. The degree of anaplasia and dedifferentiation of the individual cells comprising the neoplasm determines its degree of malignancy. Thus, neoplasms of higher grade are relatively easier to diagnose by the cytologic method. Such has been my experience. In fact, certain areas presenting low grade neoplasms primarily, such as the fundus of the uterus and the bladder, offer almost insurmountable obstacles to the method. One can readily see that familiarity with normal cells and characteristic neoplastic cells of a given body location are a prerequisite to any accuracy whatsoever. Certainly a general practitioner or technician is not equipped to perform such an examination satisfactorily.

Reliability of the Method Evaluated

Regarding so-called "errors" in the method from a statistical analysis of many articles embodying thousands of cases, one is lulled into a false sense of accuracy. One frequently sees such statistics as "100 cases examined by vaginal smear method; 20 cases reported positive and 18 cases proved by biopsy—error 2 per cent." On close examination, however, one sees that the error is not 2 per cent, but 2 errors out of 18 proved diagnoses, or 11 per cent. Also, the word

¹Read before the Florida Medical Association, Seventy-Sixth Annual Meeting, Hollywood, April 24, 1950.

“error” is misleading. There are only three possible sources of “error” in the method. First, the examiner may miss the malignant cells; secondly, the examiner may fail to recognize the malignant cells; thirdly, the malignant cells may not be present on the slide. The first two are shortcomings of the examiner and may be eliminated only by education and practice. This observation is borne out by the fact that Woolner and McDonald³ decreased their error in the cytologic diagnosis of bronchogenic carcinoma from 2 per cent in 150 cases in an investigative series to 0.7 per cent in 150 cases in a later evaluative series. The third is a limitation of the method, and may be partly overcome by repeated examinations.

Certain authors⁴ claim that the vaginal smear is as reliable as a biopsy, but still nearly all workers use the biopsy as a measure of accuracy of the smear. The only limit of accuracy of biopsy is, however, the ability of the surgeon and pathologist to obtain and interpret the tissue correctly. Everyone knows that if a pathologist is to render a positive diagnosis of malignant disease, he must have malignant tissue to study. If the surgeon obtains a specimen for biopsy from a benign area, he can only expect a benign report. The same holds true for cytologic smears.

It has been claimed that one may diagnose early cancer, precancerous changes, and carcinoma in situ by the cytologic method. To my knowledge, no one can diagnose precancerous changes by this or any other method. Furthermore, since the method depends wholly on exfoliation, there is some question as to whether or not exfoliation is a part of the symptom complex of early cancer. Surely carcinoma in situ may be diagnosed by the cytologic method. If, however, the lesion is large enough to be seen with the naked eye, biopsy is certainly indicated. Furthermore, any attempt to diagnose type and location of a malignant lesion by cytologic study is an extremely hazardous procedure.

As soon as the pathologist becomes cognizant of his own limitations and the limitations of the method, the so-called error will be reduced to the vanishing point. In examining over 25,000 frozen sections I have been faced with a similar problem. Pathologists who perform frozen sections only rarely and amid great ceremony think that they must make a definite commitment each time, or jeopardize their standing among their surgical friends. One must realize that no one can make a diagnosis in every case, whether in pathology or

any other branch of medicine. Where frozen sections are routine, no one gives a second thought when the pathologist defers a diagnosis for further study. When, however, the same pathologist does render a definite opinion, the surgeons have the utmost confidence in his decision and perform their surgery accordingly. When the cytologists assume such an attitude, and render their opinions as positive, doubtful (please repeat) and negative, then the cytologic method will be well on its way to maturity. Also, one must remember that in this type of examination a report of negative results does not rule out malignant disease, and if the clinician is still in doubt, he should request additional examinations.

As for using the vaginal smear as part of a semiannual check-up on women over 30 years of age, one can readily see that such a program is not practical. All of the pathologists in the country, working full time on this procedure alone, could not complete such an examination.

Analysis of Series

The present study reports 446 cases examined by the cytologic method. The results in 30 cases are reported as positive, in 8 as doubtful (repeat), and in 408 as negative (table 1). Of the 14 cases listed under miscellaneous, the 4 positive results are from 3 lymph node aspirations and 1 liver aspiration. The negative smears were taken from 1 pancreatic aspiration, 1 prostatic aspiration, 1 scrotal aspiration, 2 lymph node aspirations, 1 caudal canal aspiration and 2 breast nipple aspirations. Also included in this group are smears from a bladder neck and vocal cord.

Table 1.—Summary of 446 Cytologic Examinations

Material	Positive	Doubtful (Repeat)	Negative
Pleural Fluid	7	4	19
Ascitic Fluid	8	0	4
Cervix	4	2	29
Vaginal Secretion	2	2	28
Urine	3	0	296
Bronchus	1	0	9
Stomach	1	0	9
Sputum	0	0	4
Miscellaneous	4	0	10
Total	30	8	408

In summary, one can say that cytologic examination is a valuable adjunct to the diagnostic armamentarium of the pathologist. It is effective only when employed as a single rung on the ladder of diagnosis, and must be evaluated only by experts. Any attempt to use cytologic examination

as a sole diagnostic aid, particularly by untrained personnel, can lead only to chaos and condemnation of the method by physicians and public alike.

Summary

Cytologic study of body fluids and secretions is a valuable aid in the diagnosis of malignant disease.

It is a difficult and time-consuming procedure and must be left in experienced hands.

Greatest accuracy will be attained by using cytologic studies in conjunction with tissue sections, and sections of blocks made from centrifugates.

A definite opinion cannot be rendered on all slides.

Slides should be reported as negative, doubtful (please repeat) and positive.

Positive reports should be confirmed by biopsy if possible before surgery.

No known stain is specific for malignant cells, and the usual stains employed by the examiner in his routine work are best for him to use.

There is no single morphologic characteristic which will differentiate a malignant from a non-malignant cell.

The method must be tried and evaluated, and its value in the diagnosis of cancer must be established by each person employing it.

Types and locations of malignant lesions cannot usually be established from a cytologic study.

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Box 6286.

Discussion

DR. V. MARKLIN JOHNSON, West Palm Beach: I certainly have enjoyed this paper by Dr. Murray. I think that most of you in the audience will consider it a critical assay of this particular method of early cancer diagnosis. Moreover, I do not believe anyone can refute any of Dr. Murray's statements.

The question which arises, and which I would like to discuss, is who makes these examinations and on whom should they be made?

Most of us who have practiced pathology believe that we have the inside track on this particular type of diagnosis. That is not my present opinion, because I am of the opinion that while we have dealt in tissue pathology

for years, let us say, cytologic diagnosis as used by some really opens another field.

The sections on the slides which Dr. Murray has shown were included under the title of cytologic diagnosis, but most of those showed little bits of tissue. Some of us have gone to centers where this diagnostic procedure has been taught, and I am sure that all of us who have been there have learned much.

Another debatable issue is the method of reporting results. Some propose a report including five designations, namely, Classes I to V. This is the method used by Dr. Papanicolaou. The first two designations indicate no evidence of malignant disease.

The Boston groups, on the other hand, favor Dr. Murray's concept of either negative, doubtful or positive. I think we went through this same sort of game in the field of serologic examination. We used to report 1 plus, 2 plus, and so forth. Finally, we came around to the universally used method of negative, doubtful or positive, and when doubtful, repeat. I think that is most sensible. Many people other than members of the profession have entered this field of diagnosis. I would hesitate to get into any argument as to whether they should or should not attempt it. It should suffice to say that one should know his limitations, and if he is not equipped with knowledge to do these examinations, he should recognize it and should so state to the doctor who submits smears for examinations.

The next question is, on whom should these tests be made? In Dr. Murray's paper, which I had the pleasure of reading last night, I think he mentioned the fact that if this method were attempted without screening in all examinations of the female genital tract, there are not enough pathologists trained to cover the number of examinations which would become necessary. I think for this group, the reason that the Scientific Committee selected this paper on pathology was to bring to you some solution to that problem.

Most cancers of the uterus are accompanied by bleeding and by a certain amount of leukocytic exudation. You might say to me, what about early carcinoma? I think analysis will show that in some of these cases bleeding did not occur. Nevertheless, if you, as physicians, would check by cytologic examination and biopsy, whether or not the lesion is visible, every case that you see in which there is bleeding or any type of bleeding plus exudation, I think that alone would uncover many cases of carcinoma of the female genital tract that now go unnoticed until it is almost too late to do anything about it.

I have enjoyed discussing Dr. Murray's paper.

DR. JAMES N. PATTERSON, Tampa: Dr. Murray has covered, I think, in the short space of time allotted him, quite adequately the subject of the cytologic method of diagnosis. Most pathologists prefer, if given a choice, to examine biopsy specimens rather than smears because of the opportunity to study the relationship of the cells and stroma as well as individual cells, and because they do not have to rely on the structure of the individual cells alone for diagnosis. There are times, however, when it is not practical or may even be impossible to obtain a biopsy, and in such cases the smear method is indispensable. There is no question that this procedure has proved itself of great value in many cases.

One strongly positive smear should never be disregarded even though repeated smears or even a biopsy or two give negative results. The patient in such a case should be watched closely because in many patients of this type there afterwards develops a full-blown, easily recognizable, cancer. The pathologist can be of the greatest service in recognizing early malignant lesions still in the amenable stage and yet without objective finding recognizable by a physician. The Papanicolaou test has made many of these early diagnoses possible.

One of the handicaps of the smear method is the fact that it is a time-consuming examination for the pathologist while a biopsy is much less tedious and requires less time. The time element is most important in diagnosis by the smear method.

Dr. Murray should be congratulated on bringing some

of these difficulties to your attention. The smear diagnosis is of importance, but it certainly should supplement and not replace the time-proved biopsy method.

DR. MURRAY, concluding: I should like to thank Dr. Johnson and Dr. Patterson for their discussions and ideas, and I would particularly emphasize what Dr. Patterson said about one positive smear. One definitely proved positive smear would certainly indicate that that patient should be followed closely.

In some cases, it has been proved that this type of

examination can be almost 100 per cent successful, and it has been followed by surgery by one large group in the country.

In closing, let me say that this is a valuable method, but it must be used as an adjunct, along with physical examination, other diagnostic procedures and biopsy. No one would want to submit to surgery on any one positive factor. The more facts we can assemble before submitting the patient to surgery, the more certain we are to do the patient good and certainly not harm.

Chronic Pyuria in Infants and Children

MEREDITH CAMPBELL, M.D.

NEW YORK

Although it has been clinically convenient in the past to indicate urinary infections as pyelitis, the designation should be pyuria, acute or chronic, until the anatomic diagnosis is established. In the vast majority of cases of renal infection, loosely designated as pyelitis, the fundamental pathologic lesion is an interstitial suppurative pyelonephritis. Yet pyuria may exist when no organisms can be demonstrated in the body, and here obstruction, calculus or trauma is the usual cause; amicrobic pyuria has also been attributed to virus infection.

Chronic pyuria may follow an apparently satisfactory clinical recovery from acute urinary infection or may be discovered at the time of routine examination of the urine when some nonurologic manifestation is under investigation. In the study of urinary infection in patients of all ages, in the urinalysis the pus, blood and bacterial content are of primary interest. Yet diabetics are particularly prone to staphylococcic infection. When urinary infection is under investigation, aseptic collection of the specimen is of prime importance, and in females of all ages only catheterized specimens should be studied, both for the microscopic examination and bacteriologic culture as well. In the male, a satisfactory specimen can usually be obtained by retraction of the prepuce followed by liberal washing of the glans penis and separated meatus with mercury oxycyanide or bichloride 1:1000, following which the patient voids. After a few cubic centimeters of urine have been passed, a sterile receptacle is introduced into the stream to collect the specimen for routine analysis and

bacteriologic studies. If this technic cannot satisfactorily be followed, employ catheterization. It is notable that only those leukocytes which show the polymorphic or pawnbroker's nucleus should be identified as pus cells; more than 3 to 5 cells per low power field are abnormal. In the laboratory investigation, determination of the type and character of the invading organisms is essential from the therapeutic standpoint since upon this finding will rest the specific choice of chemotherapy or antibiotic therapy. Untold thousands of doses of penicillin have been administered in colon bacillus urinary infection, this antibiotic having no effect upon this group of organisms.

Urinary infection is the direct result of bacterial invasion of the urinary tract; the organisms reach the kidney chiefly by the descending or hematogenous route although unquestionably the ascending or urogenous route from infections of the lower part of the urinary tract may occur and notably when infravesical blockage occurs. The chief predisposing factor in the development of urinary infection is obstruction, which in children is predominantly congenital and of wide variety, ranging from stenosis of the prepuce or external urethral meatus to stricture of a renal calyx. Not only does obstruction predispose to the development of urinary infection, but once infection is established, its maintenance is favored by urinary stasis. Until the development of modern chemotherapy and antibiotic therapy, urinary infection could not be eradicated until the associated etiologic obstruction was eliminated. The bacteriologic cure of urinary infection by methenamine or urotropin alone suggested that no important ob-

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Read before the Florida Medical Association, Seventy-Sixth Annual Meeting, Hollywood, April 24, 1950.

struction was present. As a corollary and since urinary infection today can be cured even in the presence of pronounced urinary obstruction, patients thus benefited should not be discharged as cured until at least a satisfactory excretory urographic study has shown that the urinary tract is morphologically normal and free from obstruction.

Complete Urologic Examination

When persistent pyuria (pyuria lasting more than four weeks may be designated as chronic), has been demonstrated, intensive chemotherapy and/or antibiotic therapy should be employed according to bacteriologic indication, which in turn implies careful bacterial study of the properly collected specimen of urine. When two weeks of such intensive medical therapy fails to cure the infection as evidenced by at least two sterile cultures of aseptically collected urine, complete urologic examination should be carried out. This properly entails cystoscopic investigation usually with ureteral catheterization, divided renal function tests and bilateral retrograde pyelography. Only by such careful systematic study can the correct anatomic diagnosis be determined. Cystoscopic investigations carried out in thousands of infants and children have amply demonstrated that instrumental reactions in the young occur far less frequently following urologic investigation than they do in adults. In no instance should reluctance of the physician or parent to have the child subjected to such investigation be accepted as a contraindication to its performance when proper indications exist.

Therapeutic Measures

When the anatomic abnormalities and pathologic changes in the urinary tract have been determined, rational treatment will be directed toward correction of demonstrated lesions according to the specific indications; often this entails radical surgery. In many cases conservative therapy suffices, notably by instrumental dilation of a strictured channel. At the other extreme, nephrectomy, ureteronephrectomy or ureteroheminephrectomy is frequently required. The multiplicity of lesions etiologically associated with persistent pyuria is too extensive to permit detailed discussion here. Yet illustration by specific case citations cannot but impress one with the relatively high incidence of these various forms of urologic disease in the young, their debilitating morbidity, and the potentially high mortality they engender if permitted to persist.

Chief Etiologic Factors

Many of the renal lesions are secondary to ureteral disease and notably to obstruction. My associates and I have shown that about 2 per cent of all persons are born with some form of obstruction of the upper part of the urinary tract, and here congenital ureteral stricture rates first. Most of the strictures of this type, which are simply anatomic narrowings comparable to similar narrowings in the urethra, and the intestinal, biliary, pulmonary and cardiac and vascular systems, show no local inflammatory reaction except as secondary infection may have occurred. Congenital ureteral stricture is of the highest incidence at the ureterovesical junction, is next most frequent at the ureteropelvic junction, and is of the lowest incidence in the body of the ureter. We have found as many as three congenital strictures in one ureter. As a result of the obstruction, the proximal urinary tract gradually becomes dilated with the appearance of clinical hydronephrosis, in which, in turn, infection can always be anticipated.

Other obstructions at the pelvic outlet include aberrant vessels, notably anomalous lower renal polar arteries or veins passing from the kidney to the renal pedicle or more particularly to the aorta or vena cava respectively, and in crossing the ureter they may induce compression and obstruction. Periureteral fibrous bands or ureteral kinks may also cause blockage. In rare instances, congenital stricture of a renal calyx induces localized hydrocalyx. Other less common renal lesions include stone and renal tuberculosis. Parenthetically, 1 in every 50 cases of persistent pyuria in the young is due to surgical caseous renal tuberculosis. Much less frequently, infected renal tumor, persistent renal abscess or perinephric abscess causes persistent pyuria.

Ureteral reduplication occurs about once in every 150 patients and may be complete or incomplete, unilateral or bilateral. Often in this anomaly one ureter drains freely while the other is obstructed. This condition gives rise to hydronephrosis and hydroureter of one half of the reduplication which, infected, becomes infected hydroureter and infected hydronephrosis or may progress to pyoureter and pyonephrosis of the involved segment. Here ureteroheminephrectomy is the usual treatment indicated, with removal of the diseased half of the kidney and its ureter to leave the normally functioning segment and its normal ureter.

Ureterocele or intravesical cyst of the ureter is one of the commoner ureterovesical malformations and results from urinary pressure against a pin-hole size ureteral orifice. In some instances the ureterocele is bilateral, and we have even found it reduplicated on one side. Moreover, the ureterocele may occlude the vesical outlet to cause urinary stasis and difficulty in urination or in females may even prolapse through the urethra. Cystographically the ureterocele is commonly demonstrated as an enormous filling defect in the cystographic outline of the bladder. Although cystoscopic incision of the ureterocele may establish free urinary drainage from above, the lesion is best excised either transurethraly or suprapubically.

Obstructions at the bladder outlet or peripherally in children are nearly all congenital, the notable exceptions being traumatic or gonorrheal urethral strictures, which fortunately are comparatively rare. At the vesical outlet, obstruction and vesical residuum may result from congenital contracture of the vesical outlet, spastic neuromuscular vesical disease, congenital valvular obstruction of the prostatic urethra, congenital hypertrophy of the verumontanum, urethral stricture and particularly congenital stenosis of the external urethral meatus. Of these lesions the last is by far the commonest and may cause obstruction as grave as that produced by any of the others mentioned. In many cases we have demonstrated the entire urinary tract to be widely dilated behind the congenitally stenosed urethral meatus.

Prime Therapeutic Aim and Test of Cure

In all of these cases the diagnosis can readily be made by complete urologic investigation, and removal of the obstruction is the primary surgical consideration. In some instances conservative instrumental dilation suffices, but commonly surgical division of stricture or transurethral resection of other congenital obstructing lesions of the lower tract is necessary. Yet irrespective of the nature of the obstructing lesion and the completeness of its eradication, no patient should be discharged as cured until at least two negative cultures of aseptically collected specimens have been obtained. If this test of cure is rigidly observed, recurrence of urinary infection will indeed be rare and mild. Failure to sterilize the urine invites recurrent exacerbations of urinary infection which, as in the antecedent history of the patient, periodically dot his career and increasingly scar his kidneys.

Summary

The more important considerations in the problem of persistent pyuria in the young are considered. Complete urologic examination is indicated in practically every case. Urologic treatment will be based upon the demonstrated pathologic abnormalities; eradication of the obstruction is the prime therapeutic aim, and no patient should be discharged as cured until free drainage has been established and the urine has been sterilized.

140 East Fifty-Fourth Street.

ANNOUNCEMENT MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. Lloyd J. Netto, has announced that the dates of the four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to make a note of these dates and make plans to attend the meeting in his district and any of the other three meetings as desired.

Marianna, Monday, Oct. 30, 1950
Ocala, Wednesday, Nov. 1, 1950

Fort Myers, Thursday, Nov. 2, 1950
W. Palm Beach, Friday, Nov. 3, 1950

The Prediabetic State and Its Clinical Importance

JOSEPH H. BARACH, M.D.
PITTSBURGH, PA.

If we are to consider the prediabetic state, let us first of all define our terms; otherwise we may find ourselves thinking along different lines and even lose ourselves in a tangled maze. By prediabetes, for the purpose of our discussion today, I mean the background of the person in whom sooner or later will develop the full blown picture of the disease. It is not always a simple matter to state positively that a certain condition, common to many persons with diabetes, is actually a cause leading to the disease, or that it is an effect of the hidden diabetes which is on the way. To make this point clear, I would pose the question: Is the obesity which occurs in 80 to 90 per cent of our diabetic patients a cause of diabetes or does it actually represent an early stage of the disease? Unless you have given the question considerable thought, I would hasten to suggest that you do not answer it too quickly even to yourselves. With this example in mind, a broad consideration of the many facts which are found in the history of the diabetic patient allows the building up of a background which is typical for the average person with diabetes. Until the day comes when the specific and ultimate cause of diabetes has been found, and we can direct all of our therapeutic aims and efforts at correcting or removing the underlying causes of this disease, our greatest opportunity of helping the diabetic patient lies in a thorough understanding of the prediabetic phase of this disease. In this prediabetic phase or in the preclinical phase of diabetes, even if we cannot avert the disease entirely, we assuredly can delay it for a considerable time and perhaps for a long time in many patients.

There is much that is unknown in the history of the person with diabetes. One may well ask why it is that diabetes may make its appearance

in a child 1 year old, whose organs and tissues have not yet been subject to wear and tear, and in another, a man or woman at the age of 50 or 60 or even 80 to 90 years, who has to a great extent completed the cycle of life. Again I would suggest — let not your answer to this question be given too quickly nor with too much certainty.

In this sense, we approach the problem of the hour to see how useful we can make it. With a broad understanding of this problem and an intense drive for the detection of the disease in its earliest stages, we assuredly believe that a great deal can be accomplished.

Age at Onset

There is a certain chronology to disease. There are those diseases which belong to childhood, those of middle life and those which naturally occur in the senescent period of life. Diabetes makes its appearance most frequently between the ages of 35 and 60, and that is the time when we should be on the lookout for it. Once it becomes known that the patient is potentially diabetic, the only thing left to us, if possible, is to delay the onset of the disease, which, by all that we know, can be done. As time goes on, we hope to control such cases more and more, by early detection and control of those factors during the prediabetic state.

Sex as a Factor in Diabetes

There are nearly 6 females to 4 males with diabetes. This ratio means that if we are to reduce the total number of persons with this disease, we should help to create the conditions which tend to delay or prevent its onset. We should do what is necessary to control the tendency to obesity, particularly in women. We should teach proper dieting, interest in outdoor life and the advantages of early diagnosis of diabetes. It should be realized that women suffer all the ravages of this disease, and by actual count, proportionately more women suffer lesions of the extremities than men.

From the University of Pittsburgh, School of Medicine.
Read before the Diabetes Seminar, Jacksonville, March 28, 1949.

Occupation

As we have always known concerning the mode of living of the diabetic person, the history usually is one of indoor living, and a nervous life as compared with the man or woman whose physical and mental activities are equalized or balanced and in physiologic proportions.

It is no accident or coincidence that more male restaurateurs have diabetes more frequently than others. Whatever the compelling forces in our daily lives may be, nature insists on her own established order, inexorably, and does not yield nor abandon her laws of cause and effect.

Inheritance

In the English-speaking world at least, scientific workers believe in the forces of heredity. We still believe that there are such things as chromosomes and genes involved in the concept of heredity, regardless of Lysenko in Russia.¹ We still believe that Gregor Mendel in 1865 stated one of nature's basic truths when he enunciated his concept of segregation and transmission of characters. On the basis of this concept, as best we know it, diabetes is an inheritable disease, and it is transmitted from one generation to another. In studying our case histories, we find that 44.5 per cent of our patients give a history of a known blood relative having diabetes. Personally, I believe the figures would be much higher if our patients actually knew more of their relatives and their life histories. Out of this array of studied facts, Pincus and White² have evolved dicta, which doubtless are familiar to most of you already. If we could utilize this knowledge of inheritance as a guide, we might reduce the incidence of diabetes considerably, in a comparatively few generations. See figure 1.

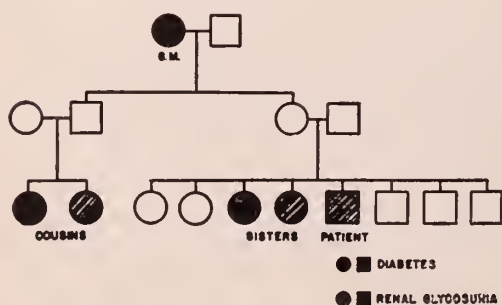


Fig. 1.—Inheritance—diabetes and renal glycosuria.

Obesity

More than 80 per cent of diabetic patients give a history of obesity. I consider this obesity as part of the prediabetic state. I have seen diabetic children 4 or 5 years of age who had gone through periods of obesity, however short their lives, prior to the onset of glycosuria.

Both in the adult and in the child, however marked the tendency, whether it is inherited or acquired, obesity is controllable, to a large extent, by diet restriction. Without greater food intake than actual requirement, there would be comparatively little if any obesity. We do not know all that we would like to know about the pathologic physiology of obesity in the prediabetic and in the nondiabetic person; but the obesity itself and its clinical implications are sufficiently understandable to realize its importance and its undesirability. Certainly an increase of 20 to 70 pounds in body weight is something to be taken seriously, by both doctor and patient.

Glucose Tolerance in the Prediabetic Person

In a diabetic family, all obese members should be studied for abnormal glucose tolerance (fig. 2). It is also good practice to study other obese persons with that in mind.

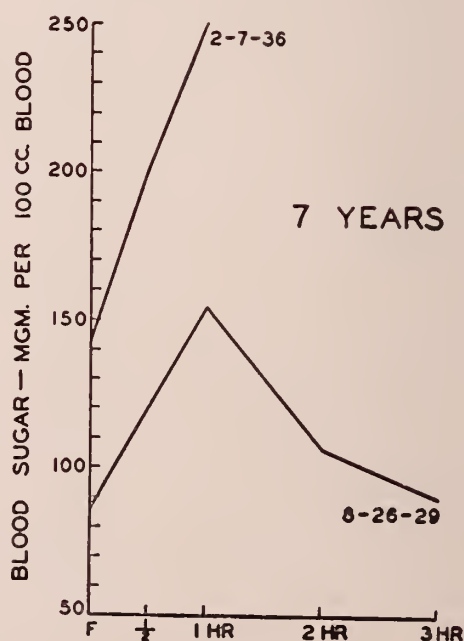


Fig. 2.—Advancing diabetes.

If the tolerance test gives positive results, then the indication for a restoration to normal weight is imperative; and that, of course, means strict attention to diet. If the test is found to produce a normal curve, one may not assume too readily that it will always be normal.

Any way one takes it, obesity is a metabolic evil, it should be held in suspicion, and it should be avoided or corrected if possible.

Blood Pressure

Little need be said concerning blood pressure in the diabetic or in the prediabetic patient. A study of our diabetic patients revealed that 56.8 per cent had normal pressure, and in 32 per cent there was hypertension. Most of our patients were men and women between the ages of 40 and 60, in whom hypertension is to be expected.

It cannot be said that diabetes of itself is a cause of hypertension, nor that hypertension is a cause of diabetes. Actually, at the height of the diabetes, both hyperglycemia and polyuria are likely to be accompanied by a lowered arterial pressure.

The Nervous System

Insult to the nervous system, whether it be somatic or psychic, has its disturbing effects, in so far as hyperglycemia and glycosuria are concerned. If we add up a lifetime of such nervous impacts, day in and day out, it is not difficult to visualize what the sum total may be. As an example of injury to the nervous system, every physician and surgeon is aware of the comparative frequency with which diabetes appears in cases of extensive fractures of bones. In regard to physical injury to the nervous system, figure 3 shows glucose tolerance curves after brain concussion and brain tumor. A mild case of diabetes becomes a severe case after fracture of the skull.

A recent experience illustrates the psychic aspect. The patient in this case is mildly diabetic. Ordinarily his disease is kept under good control by means of a maintenance diet, without insulin. Recently on returning from a meeting where he presented a discussion at one of the professional societies, he found that he could get an earlier train home, and it was necessary that he exchange his Pullman reservations. He hurried to the ticket office, where he had to stand in line to make this

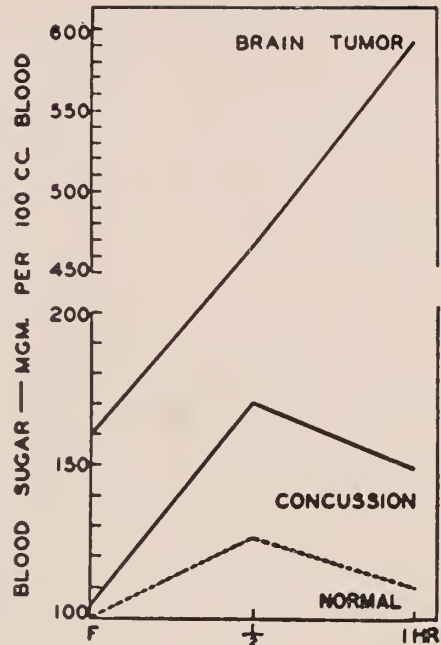


Fig. 3.—Brain injury—diabetes.

exchange, while the ticket agent was leisurely making a reservation for a passenger to California.

After waiting forty minutes, the professor blew up and had a fight with the ticket agent and then with the station master. He missed the train, of course. The following morning, his urine sugar was 4 plus although the urine had been normal for a week before this incident. When I saw him the next day, he laughed at himself as we studied his urine sugar chart. His only words, and mine, too, were, "Of course, of course, that is the expected thing." I have seen this happen thousands of times, brought about in a thousand ways, all of which verifies the old adage: "In Wall Street, when stocks go down, sugar goes up." This is an example of what we mean by the "nervous" life to which so many of us are exposed from day to day.

Diseases of the Liver and Gallbladder

The occurrence of almost 200 cases of disease of the liver and gallbladder in a series of 1,300 diabetics bespeaks a close clinical relationship (table 1).

Functions of the pancreas, liver and gallbladder suggest a physiologic and pathologic interrelationship. In figure 2 the glucose tolerance curves in a patient with disease of the gallbladder show a prediabetic state of seven years' duration. This, I am sure, occurs more frequently than is generally recognized. I have a group of such cases collected over the years.

Table 1.—198 Cases of Liver and Gallbladder Disease in 1300 Diabetics

	Cases
Preceding jaundice	55
Gallbladder disease	58
Gallbladder removed	26
Diseased liver—demonstrable	26
Enlargement of liver (simple)	18
Abscess of liver	3
Cirrhosis of liver	2
Bronzing of skin, distinct	6
Hemochromatosis, positive	4
Total	198

A Lesson from China

By all the evidence that we can gather, there is much less diabetes, decidedly less arteriosclerosis and almost no atherosclerosis with its coronary disease, detected in the anatomic and pathologic laboratories of Chinese hospitals and medical schools. Why is this? If for no other reason than to stimulate your thinking along these lines, I should like to recall the following:

1. Diabetes in China, especially in Southern China and among the poor, is a mild disease clinically."
2. Chinese diabetics require smaller doses of insulin.
3. Many Chinese are sensitive to insulin and have reactions more frequently and more severely than do patients in this country.
4. In China diabetic coma seldom occurs, and diabetic gangrene not at all. No one seems to encounter cases of coronary occlusion in the Chinese. High arterial pressure is comparatively uncommon.
5. The Chinese as a people work more and they work harder than we do, to earn their living. They have few labor-saving machines.
6. The Chinese live on a high carbohydrate diet. Their diet is low in animal protein and low in animal fats. Milk and butter as daily food are practically unknown in China. This diet gives them a low fat and a low cholesterol intake. In the United States there is one cow for every five persons, and dairying is the third largest industry in our agriculture.
7. Reports from the Department of Physiology, Tsing Hua University, revealed that in a group of 11,388 Chinese soldiers, the average diet was carbohydrate (rice) 762 Gm., vegetable protein 76 Gm. and fat 10 Gm., with a total of 3,442 calories per day. Chinese students in this school subsisted on carbohydrate 342 Gm., protein 41 Gm. and fat 8 Gm., a total of 1,604 calories.

The lesson from these observations might well be that a diet high in carbohydrate, relatively low

in protein which is mainly vegetable protein, and inordinately low in fat is the standard for a people who work hard physically and are seemingly free of diabetes and almost completely free of its complications and sequelae.

Various observers have reported the comparative scarcity of atherosclerosis and arteriosclerosis in Central America and in South Pacific areas and in certain parts of India where the diet is decidedly low in meats and fats. These are significant clinical observations and deserve most careful study in a time like ours when the death rate from arteriosclerosis in all of its phases is appallingly high.

Conclusion

In so far as diabetes is concerned, I am inclined to believe that a real therapeutic advance will come with a lowering of the animal fat portion of the diet and replacement of a portion of the animal protein of our present day diets with vegetable proteins, at the same time keeping the total diet with all of its required nutrients at a good maintenance level. Manufacturers of insulin will tell you that the pancreas of animals fed on rich grasses has a greater yield than that of those which have subsisted on lean pastures; and I have been informed that extra feedings before slaughter increase the insulin yield of the pancreas up to 25 per cent. It is known the world over that the incidence of diabetes is low where food is scarce, and it is not a mere coincidence that this country, the best fed land in the world, has the highest incidence of diabetes, its sequelae, and also its complications. What we see from day to day in our clinical work is that a high blood cholesterol is definitely lowered in most cases after two weeks in the hospital on a weighed and measured diet. Our hope is that hyperlipemia or hypercholesterolemia in most patients will be found to be a reversible process.

By this last statement, I do not mean that cholesterol of and by itself is the specific cause of the complicating lesions. What I do believe is that hyperlipemia and hypercholesterolemia are part of that process, and that they may serve as an index to what is going on, but is not yet fully understood.

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Acute Renal Insufficiency: A Review

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AND

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MIAMI

Acute renal insufficiency as a specific clinical and pathologic entity has been the subject of much discussion during the last few years because of studies made into its basic nature and because of a revival of interest in therapeutic measures for its management. Since it is a problem that may confront any practitioner and one which can be solved by proper management, it may be valuable to review the problem to date.

In 1946, Lucke²⁰ reported identical pathologic findings in a series of cases of acute renal failure associated with various disease states. He named this pathologic entity lower nephron nephrosis. Multiple synonyms (table 1) have been used to describe this condition.

Table 1.—Synonyms of Lower Nephron Nephrosis

1. Hemoglobinuric nephrosis
2. Acute parenchymatous nephritis
3. Acute tubular nephritis
4. Acute toxic nephrosis
5. Post-traumatic renal injury
6. Renal anoxia syndrome
7. Crush syndrome
8. Shock kidney

Some of the disease states with which lower nephron nephrosis has been associated are shown in table 2.

Table 2.—Lower Nephron Nephrosis Associated with

1. Intravascular hemolytic reactions³⁷
 - a. Incompatible transfusions
 - b. Blackwater fever
 - c. Toxins
 - d. Transurethral prostatectomy
2. Crushing injuries
3. Burns
4. Nontraumatic muscular ischemia
5. Heat stroke
6. Toxemia of pregnancy
7. Uteroplacental damage
8. Abortion
9. Sulfonamide intoxication
10. Alkalosis
11. Poisoning with vegetable and chemical agents
12. Surgery with hypotension
13. Hepatorenal syndrome

The important initiating factor in these conditions appeared to be destruction of muscle and/or blood, shock, and loss of fluids and electrolytes from vomiting, or diarrhea, or both.

Pathologically, the kidneys are enlarged and heavy; the cortex is pale, the medulla dark. Histologically, there are focal degeneration and necrosis of the distal segments of the tubules with or without brown casts of heme compounds in the lower nephron and collecting tubules. There is little or no change in the glomeruli or proximal tubules. Liver damage may or may not be prominent. In the nephroses of mercury toxicity and carbon tetrachloride toxicity, the pathologic findings in the kidneys are more extensive since the entire tubule shows necrosis. From a clinical and physiologic point of view, however, these conditions should be grouped with the true lower nephron nephroses. Regeneration of tubular epithelium begins about the fifth day; if death does not result from mismanagement of fluid and electrolyte balance or potassium intoxication, complete repair will ensue. This concept of a self-limited disease is the all-important one in approaching the problem of therapy, because the patient who can be tided over until regeneration of the tubular epithelium can take place will recover completely.

The pathogenesis of the renal lesion in all except the true toxic nephroses is not definitely known. There are a number of theories.^{4,11,12,23,26,27} The consensus, however, is that renal anoxia is the main factor. The liberation and precipitation of heme compounds and the effect of nephrotoxic substances derived from injured tissue are also considered important. The mechanism of the initial oliguria and anuria is believed to be secondary to shock, which produces renal vasoconstriction and decreased blood volume and thus reduces glomerular filtration. Later oliguria and anuria are maintained by an increased intrarenal

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pressure due to dilatation of the tubules, interstitial edema and inflammatory exudates, by obstruction of the tubules, and by passage of the glomerular filtrate through the damaged tubular walls. The majority of workers believe that the last named condition is the most significant in the maintenance of the oliguria and anuria.

With or without a period of shock, depending upon the associated conditions, nausea, vomiting, weakness, malaise, and sometimes pain in the abdomen and back develop, and then with an insidious or abrupt onset the oliguria or anuria appears. The subsequent clinical course depends largely upon the therapy. If fluid balance is not maintained, edema, hypertension and cerebral symptoms of coma, irrational loud talk, muscular twitching and convulsions appear. The last named symptoms are frequently incorrectly ascribed to uremia rather than to the cerebral edema of water intoxication. Death may result from pulmonary or cerebral edema, or rarely later in the course of the disease, from potassium intoxication. In patients who recover after a period of anuria, the urinary output gradually increases to the point of massive diuresis. This diuresis may be associated with collapse and with the clinical state of salt depletion and dehydration. Dehydration and hypochloremia may rarely be the cause of death in this period of diuresis when recovery seems imminent.

The biochemical and physiologic alterations have been carefully studied and reported in detail by Mallory and his co-workers,²⁴ and Burnett and his associates.^{6,7,8} Briefly, they found the expected rise in the serum nonprotein nitrogen, urea, uric acid, creatinine, potassium and phosphate with the reciprocal fall in serum calcium. The serum carbon-dioxide combining power frequently fell slowly during the course of the anuria, but the authors warned against too vigorous treatment of this metabolic acidosis, because the blood hydrogen-ion concentration was usually normal and in their cases the patients tolerated alkalis poorly. The cause of this metabolic acidosis is not known. If it were due to low total base, the carbon-dioxide combining power should be lower in those cases with a low plasma sodium, and if it were due to substitution of chlorides for carbon dioxide, the plasma chloride should be high; yet neither condition obtains. They did not study the serum levels of sulfate and other acids. Their failure to do so is unfortunate because Wakefield, Power and Keith⁴⁰ have reported a moderate to great degree of sulfate retention as a factor in the acidosis

of renal insufficiency. Abnormalities in these components might have explained their abnormally low total anion determinations.

The most interesting findings were in regard to the sodium and chlorides. The plasma levels of both of these substances were frequently low and were dependent in part upon the salt intake. The frequent absence of this correlation leads to the belief that there must be a shift of these elements from the intravascular bed to other extracellular or intracellular reservoirs. The fall in carbon-dioxide combining power was equally severe regardless of the serum levels of sodium and chloride, and there was no evidence that diminished sodium or chloride concentration in the plasma affected the course of the disease. This latter observation is especially important in the management of these cases because an attempted correction of these abnormalities, which are of themselves apparently of no great consequence and which frequently are resistant to therapy, may result in an excessive infusion of fluids and electrolytes with resulting pulmonary edema.

The blood volume increases markedly even in the absence of edema. This increase is partly related to a discrepancy between the fluid output and fluid intake. It is not a simple hydemia since the plasma protein and hematocrit are not lowered. Therefore it must represent a disturbance in the maintenance of normal extracellular fluid volume. The importance of this observation is self evident, for the administration of excessive quantities of fluid to patients who already have an increased blood volume can probably do nothing toward stimulating a return of renal function, but can only induce pulmonary edema.

These patients show great impairment of renal function. Both before and after recovery from the anuria, there is inability to concentrate the urine, and frequently there is failure to produce a highly acid or alkaline urine even in the presence of severe metabolic acidosis or alkalosis. The excretion of chlorides and other solids is markedly reduced. In addition, the urine contains varying amounts of albumin, granular or pigment casts, and frequently heme compounds. As recovery occurs, the albumin disappears and the solids increase, but the impairment of concentration may persist for months. The period of diuresis is associated with great loss of water, sodium and chloride to the point of a dangerous hyponatremia and hypochloremia.

Treatment

The primary concept in the management of acute renal insufficiency of the type described is a realization that if the patient can be given successful supportive treatment for one to three weeks, regeneration of damaged kidney tubules with ultimate complete recovery will take place. It therefore behooves the physician to so plan his therapy that it will in no way harm the patient or jeopardize the expected healing.

Recent reports have suggested several methods of internal and external hemodialysis, such as peritoneal irrigation,^{1,15,48} artificial kidney,^{2,16,18,22,33} and lavage of the gastrointestinal tract,^{25,31,35,45} as a substitute for renal function during the period of anuria. There have also appeared numerous reports on conservative medical management in these cases with emphasis on fluid restriction.^{5,10,28,40,42,43}

The various methods of hemodialysis have proved capable of removing electrolytes, products of protein metabolism and certain toxins from the blood stream, both in experimental and clinical evaluations. This aspect of the problem of the management of renal insufficiency has been reviewed elsewhere;^{1,15,18} so it will not be discussed in detail in this paper.

It will suffice to point out that the disadvantages of these methods are so great that some workers³² have given them up completely, preferring to employ medical management. The chief disadvantage in all of them is the absence of any selective ability in the dialyzing membrane. This results in either overhydration with excessive intake of electrolytes and edema or in the loss of water and electrolytes with dehydration, shock, acidosis or tetany. These factors can be partially controlled by varying the composition of the dialysate solutions, but only partially so, because the electrolyte pattern of both the blood and the dialysate is constantly changing, making fine adjustments impossible. This fact necessitates frequent blood chemistry determinations and the correction of detected abnormalities by intravenous infusion of appropriate solutions and by changes in composition of the dialysates. Additional deterring disadvantages evolve from the technical difficulties presented by the complexity of the equipment, the maintenance of sterility, and other factors. Of the three methods of hemodialysis, irrigation of the gastrointestinal tract is the simplest and most generally applicable and may have a limited use in patients with oliguria or anuria if dangerous hyperpotassemia develops, as will be brought out later.

Although fluid restriction was first suggested by Wakeman⁴⁷ in 1932, it was not until publication of the reports of Peters,³⁶ Lattimer,¹⁹ and Kugel¹⁷ in 1945 that this principle of management received much credence. Peters³⁶ based his recommendations on the concept that the chief factor in the production of the anuria was increased intrarenal pressure and that excessive fluids hampered recovery by producing or increasing interstitial renal edema. While the majority of workers now believe that the interstitial edema is not the chief factor, some agree that excessive fluids do increase the intrarenal edema and are therefore deleterious. Lattimer¹⁹ based his recommendations on autopsy findings of pulmonary edema and cerebral edema rather than uremia as the cause of death in the majority of cases. He correctly ascribed these findings to excessive fluid intake. Kugel¹⁷ also based his opinion on the analysis of autopsy findings and described 2 cases successfully managed by fluid restriction. Barksdale³ in 1946 came to identical conclusions after analysis of other autopsy data.

Mallory and his associates,²⁴ and Burnett and his co-workers⁶⁻⁸ put the restriction of fluids and electrolytes on a scientific basis with their findings of increased blood volume, low serum carbon-dioxide combining power without change in blood hydrogen-ion concentration, absence of apparent harmful effects of hypochloremia and hyponatremia and the harmful effects of alkalis. Burwell, Kinney and Finch,⁹ Thorn,⁴³ and Reuben³⁸ urged fluid restriction and used the reports of successful application to cases, analysis of mortality figures, and theoretic consideration as the basis for their contention.

The reports of Muirhead and his co-workers,²⁸⁻³² Coller, Campbell and Iob,³⁰ and Strauss^{40,41} all urged the systematic conservative approach to treatment with the so-called "three phase management," in which fluid restriction during the period of anuria and oliguria is an integral part. Muirhead and his co-workers²⁸⁻³² were the first to describe clearly the three phases of the syndrome, namely, (1) (first day) injury, (2) (first to fourteenth day) anuria and (3) (eighth to sixteenth day) salt-losing diuresis, and to give a systematic therapeutic program for each phase of the syndrome. Although there are minor differences of opinion as to the details of treatment in these cases, especially of the anuric phase, there is surprising uniformity of opinion concerning the major aspects.

FIRST PHASE: INJURY. — The first phase, that of injury involving shock, hemolysis and tissue destruction, should be approached initially from the point of view of prophylaxis, such as by prevention of hemolytic reaction and by prompt treatment to prevent shock. If the renal injury is not prevented, then the underlying condition should be treated as vigorously as possible to minimize the injury with sufficient blood, plasma and electrolytes to correct anemia, shock, dehydration and acidosis or alkalosis. Frequently, 5 to 6 liters of fluid of one type or another is needed in this initial period and can be given without fear if the type and quantity are determined by a careful analysis of the clinical and chemical aspects of the case. Whole blood is preferable to plasma in most cases.

SECOND PHASE: ANURIA.—During the second phase when oliguria and anuria are present, the fluid balance should be maintained. This can be ascertained by daily weighing and by detailed and complete studies of the fluid balance. The amount of fluid given per day should meet the insensible loss through the skin and lungs (which will vary with the body temperature, the external temperature and the humidity) and the loss by urine, stool and vomitus. Strauss⁴⁰ calculated the daily water deficit of an afebrile anuric adult to be 530 cc. as follows:

Insensible loss	1,000 cc.
Water of oxidation	470 cc.
(from metabolism of body issue)	
Daily water deficit	530 cc.

He therefore suggested that 750 cc. of 15 per cent dextrose in distilled water plus a volume of physiologic saline solution equal to the fluid lost by vomiting and diarrhea should be given daily during the phase of anuria. This is the smallest amount of fluid recommended, for most authors suggest 1,000 to 2,000 cc. daily. The smaller amount, however, seemed adequate in the cases reported by Strauss.⁴⁰ Probably 1,000 cc. plus the volume lost in urine, vomitus and diarrhea fluid should be the maximum amount of fluid permitted in a twenty-four hour period.

Although most authors suggest that the oral route of administration is preferable because of less danger of vascular overload, Strauss⁴⁰ urged only intravenous therapy with nothing by mouth. He believed that vomiting is increased by oral administration of food or fluids. Muirhead and Hill²⁹ thought that much of the nausea and vomiting is due to water intoxication so that if fluids are managed correctly, nausea and vomiting will

not occur and foods and fluids can be used orally throughout the illness. It seems probable that once vomiting has stopped and the nausea is not severe, the oral rather than the parenteral route should be used. In general the fluid should be low in sodium content. The solution most frequently given was 5 to 10 per cent dextrose in water. More hypertonic solutions were not given because of their tendency to increase blood volume. Strauss⁴⁰ and Thorn⁴³ used the slow intravenous infusion of 15 per cent dextrose in water to increase the caloric intake and thus minimize endogenous protein breakdown. They noted no harmful effects from this hypertonic solution. Others have used 25 to 50 cc. of 50 per cent dextrose intravenously, slowly, for similar purposes, but this stronger solution probably has no virtue and may cause venous thrombosis. When oral feeding is used, the diet should be of high caloric, low salt content. The protein content should be drastically restricted.

The sodium chloride intake should be carefully restricted in all cases. Barksdale³ took exception to this restriction and gave 2.5 Gm. in the form of 300 cc. of physiologic sodium chloride solution daily. In general, only that volume of physiologic saline solution equal to the volume of vomitus should be given intravenously daily. In a few cases in which the patient is first seen late in the course of the disease with severe hypochloremia and hyponatremia resulting from previous therapy with large volumes of salt-free fluid, the intravenous administration of 3 to 5 per cent saline solution in 50 to 100 cc. doses may be of value. As was pointed out previously, however, the degree of hyponatremia and hypochloremia apparently does not alter the outcome and therefore no intensive therapy should be used to correct these abnormalities.

The use of alkali is the most controversial aspect in the therapeutic regimen. Strauss⁴⁰ at one extreme advocated treatment with 1 liter of 1/6 molar lactate, (or 5 per cent sodium bicarbonate if great hemodilution is present from previous mismanagement), only if clinical evidence of acidosis appears and is substantiated by laboratory determinations. Burnett and his associates⁸ advised judicious use of alkali to relieve metabolic acidosis, but thought that the already present amount of alkali given in blood and blood substitutes will usually suffice. Others suggested that if the carbon-dioxide combining power falls below 40 or 50 mg. per hundred cubic centimeters, then

alkali therapy in the form of 4 to 6 Gm. of sodium bicarbonate by mouth or 500 to 1,000 cc. of 1/6 molar lactate intravenously should be given daily to correct this abnormality. Muirhead and Hill and their associates^{28,29,31} urged the liberal use of alkali orally and had had no apparent complications from its use. Burwell, Kinney and Finch⁹ suggested its use initially in all hemolytic reactions regardless of the blood chemistry findings. The evidence is such that unless clinical acidosis is present or the depression of carbon-dioxide combining power is great, it is probably best to withhold corrective measures since the therapy increases the sodium intake and vascular overload and may easily lead to alkalosis with increased renal damage. In addition the blood hydrogen-ion concentration is usually normal in these cases. The abnormal carbon-dioxide combining power is, therefore, more an indication of a compensatory mechanism than of a true acidosis.

Additional treatment during this phase consists of digitalization if cardiac enlargement or pulmonary congestion is noted, and the use of 10 cc. of 10 per cent calcium gluconate intravenously if tetany develops. Extreme caution should be used with both of these drugs, especially if they are used simultaneously because their metabolism is abnormal in the anuric patient and their synergistic effect is well known. If the phase of anuria persists beyond twelve to fourteen days or the amount of tissue destruction is great, there is danger that hyperpotassemia may develop. This can be detected by serum potassium determination in the larger medical centers or by taking electrocardiograms every few days and watching for evidence of potassium excess in the tracings. These changes are described in detail by Stewart, Shepard and Horger³⁰ as follows:

There is first an increase in the amplitude of the T waves as the serum potassium rises, then a decrease in amplitude of the R waves with an increase in the amplitude of the S waves. As the serum potassium reaches a level of about 10 milli-equivalent per liter, there is a disappearance of the P waves and progressive depression of the RST segments with widening of the QRS complex, so that a smooth biphasic curve of the QRST appears. With the appearance of intraventricular block, the heart rate falls progressively, until there is cardiac arrest in diastole. Other types of anomalies have been described, consisting of changes in the ST waves, T waves and RST segments and also various cardiac arrhythmias.

Should hyperpotassemia develop, it must be treated by one of the methods of internal or external hemodialysis mentioned. Probably gastrointestinal lavage with electrolyte free hypertonic solutions and correction of the resulting disturbed electrolyte balance with intravenous injection of

electrolytes is more generally available than artificial kidney or peritoneal irrigation.

THIRD PHASE: SALT-LOSING DIURESIS. — The third phase in which a salt-losing diuresis is present, is characterized by an output of urine up to 5 to 10 liters a day and with a urinary excretion of sodium chloride up to 20 to 40 Gm. in a twenty-four hour period. It is essential during this phase to replenish all water and salt to prevent dehydration and collapse. Replacement is best managed on an eight hour basis for the amounts involved are so large and the rapidity of change so great that if twenty-four hour values are used, a serious state of salt depletion and dehydration may result. The urine volume and its sodium chloride content should be measured every eight hours by the bedside method of Fantus*,^{33,44} which has an accuracy of ± 0.5 Gm. of sodium chloride per liter of urine. At first the intravenous route for replacement must be used, but later the oral route will suffice. Collier, Campbell and Iob¹⁰ suggested that once the diuresis is established, Ringer's solution should be used intravenously until oral intake is possible, and then after each voiding a 0.5 per cent solution of sodium chloride and sodium bicarbonate in an amount equal to the urine volume should be taken orally at once to maintain fluid and electrolyte balance. Blood chlorides should be checked during this period to prevent hypochloremia. These determinations are of special value in cases of sulfonamide toxicity with anuria, for in certain of these cases the phase of diuresis is associated with sodium chloride retention rather than a salt diuresis,²¹ and if sodium chloride is forced or even given in small doses, a fatal outcome will result. In these cases alone there must be given large volumes of sodium chloride free solution such as 5 per cent dextrose in distilled water intravenously or tap water by mouth during the phase of diuresis.

The results of this three phase management of renal insufficiency of the lower nephron type of nephrosis is surprisingly good as shown by a summary of the published reports (table 3). In the 46 reported cases tabulated, there were 7 deaths; in all but 2 of these there was restoration of renal function as shown by clinical and autopsy findings. In 6 of the fatal cases there were other irreversible pathologic changes of sufficient magnitude to militate against a successful outcome, regardless of the renal aspects of the case. In the remaining fatal case (37), there may have been irreversible brain damage for the patient remained semicomatose during the entire period.

Table 3.—Analysis of Forty-Six Cases

Author	Case No.	Diagnosis	Recovery of Renal Function	Out-come	Cause of Death	Revisibility of Disease State
Lattimer ¹⁰	1-3	Hemolytic transfusion reaction	Yes	Lived		
	4-6	Sulfonamide reaction	Yes	Lived		
	7	Carbon tetrachloride toxicity	Yes	Lived		
Kugel ¹⁷	8	Carbon tetrachloride toxicity	Yes	Lived		
	9	Hemolytic transfusion reaction	Yes	Lived		
Muirhead and others ²⁸⁻³²	10-18	Hemolytic transfusion reaction	Yes	Lived		
	19	Hemolytic transfusion reaction	Yes	Died	Hemorrhage after recovery of renal function	Irreversible
	20-24	Transurethral resection with hemolysis	Yes	Lived		
	25	Carbon tetrachloride toxicity	Yes	Lived		
	26	Extensive burns and hypotension	Yes	Died	Diffuse brain damage, but regeneration of kidney tubules	Probably irreversible
	27	Hemorrhage and hemolytic transfusion reaction	Yes	Lived		
	28	Surgery and hemolytic transfusion reaction	Yes	Lived		
	29	Surgery and prolonged hypotension	Yes	Lived		
	30	Delivery and prolonged hypotension	Yes	Died	Diffuse brain damage but regeneration of kidney tubules	Probably irreversible
	31	Jaundice and relative hypotension	Yes	Lived		
	32	Amigen reaction and hypotension	Yes	Lived		
	33	Trauma and prolonged hypotension	Yes	Lived		
Coller and others ¹⁰	34	Surgery and prolonged hypotension	Yes	Lived		
	35-36	Hemolytic transfusion reaction	Yes	Lived		
	37	Surgery and prolonged hypotension	Yes	Died	Died on 22nd day of dehydration, sodium and potassium depletion	Reversible
	38	Sulfonamide reaction	Yes	Lived		
	39	Hemolytic transfusion reaction	Yes	Died	Carcinoma of stomach with perforation; advanced healing of tubules	Irreversible
Strauss ^{40, 41}	40	Surgery and prolonged hypotension	No	Died	Extensive brain hemorrhage	Irreversible
	41	Toxin, questionable nature	No	Died	Potassium excess and central necrosis of liver	Probably irreversible
	42-43	Toxin, questionable nature	Yes	Lived		
	44	Bichloride of mercury toxicity	Yes	Lived		
Reuben ³⁸	45	Bichloride of mercury toxicity	Yes	Lived		
Flipse ¹⁴	46	Bichloride of mercury toxicity	Yes	Lived		
Summary: 46 cases, 7 deaths (2 without recovery of renal function)						
40 cases with reversible lesion, 1 death						
Corrected mortality 2.5 per cent						

The cause of death in this case, however, seems to have been dehydration and sodium and potassium depletion during the phase of diuresis. With only 1 death in the 40 cases with reversible disease states, the corrected mortality was only 2.5 per cent. While this figure is probably too low since fatality figures are not published as frequently as are the successful outcomes, the results are far better than those obtained either by previous medical routine (35 to 95 per cent mortality) or by peritoneal irrigation (48 per cent corrected mortality). It must be remembered also that peritoneal irrigation is not likely to be used unless persistent anuria is present whereas in some of the medically managed cases the patient was not totally anuric.

Summary

Acute renal insufficiency due to lower nephron nephrosis is associated with a large group of conditions in which there is destruction of muscle and/or blood, shock, and dehydration. The necrosis of the tubules is completely reversible if the patient can be given successful supportive treatment for one to three weeks. Autopsy material indicates that death is usually due to pulmonary and/or cerebral edema rather than uremia.

Biochemical studies suggest that the low levels of serum chloride and carbon-dioxide combining power have no relation to the ultimate outcome, being merely indications of a compensatory mechanism and as such requiring no treatment.

The disadvantages of peritoneal irrigation, artificial kidneys and lavage of the gastrointestinal tract are so great that the three phase medical management is preferable. If the phase of injury cannot be prevented, it is treated vigorously with sufficient blood, plasma and electrolyte solution to correct anemia, shock, dehydration, acidosis or alkalosis. During the phase of anuria or oliguria fluid is restricted to 1,000 cc. of 15 per cent dextrose in distilled water plus a volume of physiologic saline solution equal to the loss in urine, vomitus and diarrhea fluid. During the phase of salt-losing diuresis the fluid and electrolytes are replaced on an eight hour schedule.

A review of the 46 reported cases treated with various modifications of this method showed that there were 7 deaths, 6 in patients with irreversible extrarenal disease. There was, therefore, a corrected mortality of 1 death in 40 cases or 2.5 per cent.

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*The necessary apparatus and solutions for the bedside urine chloride concentration determination of Fantus consist of a test tube, medicine dropper, 20 per cent potassium chromate, 2.9 per cent silver nitrate and distilled water for rinsing the dropper. To 10 drops of urine in a test tube, add 1 drop of potassium chromate solution and then silver nitrate solution, a drop at a time with shaking until the contents of the test tube suddenly change from yellow to brick red. The same dropper must be used throughout and rinsed between solutions. The number of silver nitrate drops required to produce the color change equals the urine sodium chloride concentration in grams per liter. If this test is being run by unskilled personnel, it is wise frequently to run a control using the always available physiologic saline solution, 10 drops of which will require 8 to 9 drops of silver nitrate solution to produce the color change.

War Participation

Dr. Herbert E. White, president of the Association, appointed two committees on a state level early in August. They are to be known as Procurement and Assignment and Emergency Medical Service. A chairman was appointed for each committee and one member for each of the four medical districts of the state.

The A.M.A. Council on National Emergency Medical Service advised that it may be necessary to re-establish an agency similar to the Procurement and Assignment Service of World War II. On the national level, therefore, pertinent information will be disseminated with the committees on a state level, which explains the necessity for the appointment of the two committees named.

Dr. Robert B. McIver, the Association's secretary-treasurer, has directed a communication to the president of each county medical society in Florida requesting the appointment of a Procurement and Assignment committee and also a committee on Emergency Medical Service. As this Journal goes to press, quite a number of presidents have already appointed their committees and sent in the names of the doctors who are to serve.

The emergency in Korea has necessitated prompt action. There has been considerable anxiety on the part of the medical profession as to what steps will be taken and who will be personally involved as medical officers. Information as to details has been rather meager awaiting definite plans of procedure from the top level. As plans develop, the Florida physicians will receive prompt information through the various channels.

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3. Review of Fee Schedules

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(Other members on Sub-Committee 3 will appear in this space at a later date.)	

4. Blue Shield

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From Our President

HATS OFF TO THE LADIES!

The officers and members of the Woman's Auxiliary to the Florida Medical Association are to be highly commended for their fine accomplishments during the past year, with special reference to their part in the fight against socialized medicine.

A total of 134 resolutions were obtained, of which 65 were from women's organizations; among the first and strongest of the latter was one obtained from the American Federation of Women's Clubs at their 1949 meeting in Hollywood.

The activities of our Woman's Auxiliary members against socialized medicine, through their speakers' bureaus, distribution of literature, noteworthy newspaper publicity furnished to women's page editors, and the wonderful job they accomplished in the recent Senatorial race in their "Get-out-the-vote" campaign, are all deserving of highest praise. Their work has gained recognition beyond the confines of our own state, as manifested in the fact that the presidents of the Woman's Auxiliary to the American Medical Association, and to the Southern Medical Association, were guest speakers in the meeting in Hollywood of our Woman's Auxiliary.

We express the hope that all County Medical Societies will work in close cooperation with the Auxiliary members in their continued fight against state medicine.

Herbert E. White,

The Journal of the Florida Medical Association

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Writers of Medical News Urged To Be Cautious

Dr. Russell S. Boles of the University of Pennsylvania, in an unusual address before the recent meeting of the American Medical Association in San Francisco, criticized irresponsible physicians and writers for failing to judge carefully the source and content of medical news. In his chairman's address before the Section on Gastro-Enterology and Proctology, Dr. Boles said that "the reporting of medical news, in general, is of high order." He went on to say, however, that free lance writers and physicians who give out premature press releases on research that has not been substantiated were responsible for misunderstandings and confusion and that they unwittingly served as agents for poor public relations.

Dr. Boles decried premature reporting of investigations with the use of such phrases as "holds promise," "looks promising," or is entitled to "further investigation." He pointed out that scientists and ethical science writers have no desire to present medical news that may later prove to be erroneous and he stated that such items may legitimately appear in professional journals, but not in the public press, for to people in general such phrases may well imply that a cure is on the way. He emphasized the need for physicians and medical institutions to cooperate with medical writers whose experience and background permit them to evaluate new developments.

Citing the phenomenal increase in the use of penicillin and streptomycin, Dr. Boles said that extravagant and indiscriminate publicity of even proved valuable remedies is sometimes unwise. The domestic production of penicillin increased from

21,000,000,000 units in 1943 to 133,229,000,000 units in 1949; production of streptomycin increased from less than 2,000,000 grams in 1946 to 83,000,000 grams in 1949. Dr. Boles stated that this increase was out of all proportion to the known indications for the use of these two drugs and that this tremendous output resulted from arousing curiosity to the point where the public demanded these drugs in conditions for which there was no proved specific indication.

At about the same time Dr. Boles was speaking, Dr. Arthur L. Bloomfield of Stanford University Medical School, in his chairman's address before the Section on Internal Medicine, challenged one of the most publicized medical developments of recent times—the use of antihistaminics in the common cold. "There is no solid evidence," says Dr. Bloomfield, "that the true cold is influenced by antihistaminics or antibiotics, nor is there any reliable method of prevention." Various forms of traumatic rhinitis, he said, which may be amenable to antihistaminics and antibiotics are not the common cold at all.

Warnings from these two authorities are timely and should be heeded by one and all. Pseudo cures, reports of limited numbers of cases and overenthusiastic claims, when made public, endanger not only the bodies and pocketbooks of our patients but also give false hopes which end in bitter disappointment when there is no benefit. If we are to maintain relations with the public on a satisfactory level, it will be necessary for us to make sure that medical news emanates from reliable sources, that it is evaluated critically and that it is presented clearly and accurately.

World Medical Association Meeting New York, October 16-20

When the World Medical Association convenes in New York City on October 16 for its fourth general assembly, it will have an imposing list of accomplishments to its credit although it has been organized barely three years. Its membership includes the national medical associations of 40 countries. It has adopted an International Code of Ethics and also a modified Hippocratic Oath already approved by several organizations. During its brief existence it has investigated medical education in 26 countries, social security as it affects medical practice in 24 countries, cult practice in 24 countries, medical advertising in 23 countries, post-graduate medical education in 32 countries, and the status of the medical profession and medical manpower in 23 countries. These studies will be kept up to date and will be extended to cover countries not already included. Investigations of hospital facilities and of certain pharmaceutical problems in the various countries are now in progress.

The Bulletin of the World Medical Association, published quarterly, is the official organ. All publications are printed in three languages, English, French and Spanish.

Arrangements for medical contacts by physicians traveling in foreign countries is another service rendered by this worldwide organization. It also arranges lectures by physicians traveling in foreign countries.

Acting through its component national medical bodies, the World Medical Association endeavors to "enlist each of the approximately 500,000 physicians represented by them to promote, conscientiously and with unflagging zeal, all those principles that contribute to the free pursuit of scientific truth and the free exercise of their professional skill."

Certainly committed to this objective is Dr. Elmer L. Henderson, currently president of the American Medical Association, who accedes to the presidency of this world organization at the forthcoming New York meeting. As this Louisville surgeon sits at his handsome, old-fashioned, walnut, roll-top desk with the great men of medicine past and present looking down upon him from the walls above it, he will find in the ensuing months that the eyes of his medical colleagues throughout the world are focused upon him. World medicine looks confidently to him, as does American medicine, for the brilliant leadership he is capable of giving and will give unstintingly in its behalf during the crucial period immediately ahead.

Communism — Socialism's Tool

It has become more and more evident to the laity and the profession alike that the problem of combatting nationalized medicine is but one facet of the much greater problem of opposing the conversion of this country into a socialist state. The destructive pathway along which the nationalizers of medicine — and eventually the other professions, business and industry — would lead us has many diverting byways that tend to distract attention purposely from the main issue of socialization of the country. A major bypath that lately has assumed the proportions of a superhighway in the public eye is communism.

The threat of communism is indeed real and should be thoroughly aired and completely thwarted. But it should not be overlooked that the hue and cry over the inroads of communism in our midst serve conveniently to cloak the more insidious threat of socialism. Attacking communism proved a convenient expedient for the national socialists of Germany; attacking fascism likewise proved advantageous for the communists. Here in America Nazi agents cleverly inveighed against communists, and communists, in turn, condemned Nazism as a threat to American government. Always the idea was to divert attention from their own programs.

As a people we may well take heed. While we remain aroused over the grave danger of communism to our freedom-loving manner of living, let us not permit the necessity for opposition to this repugnant foreign ideology to divert our efforts from opposition to the creeping socialism that is upon us. Its methods are much more insidious and difficult to oppose than are those of communism.

While at the present time communism is underground and boring from within, the socialistic program of establishing a planned economy in a country which has always boasted of freedom of opportunity goes on apace and openly. Its designing promoters grow bolder in revealing their nefarious schemes. The growth of bureaucracies in Washington in recent years is nothing short of a national scandal; some have indeed become unmanageable, even by the Congress. Under pretense of preventing monopolies, such as those of business or utilities, there has been created a great monopoly of government.

The true American patriot wants nothing that even savors of communism. Nor does he desire to

become the victim of an old political trick — the strategy which utilizes the dislike of communism to camouflage the inroads of socialism, its precursor on our government.

We Are Opposed

Reticence with the press, traditionally characteristic of the medical profession, has boomeranged. It has unwittingly afforded socialist schemers the opportunity of creating a widespread opinion that physicians are opposed, for selfish reasons, to the improvement of medical care of the people. The absurdity of such propaganda is well known to its political proponents, but the people, the innocent and intended victims, must be fully apprised of the untruthfulness of the charges. They must be made to realize that it was refusal of the physicians of this country to bow down to the demands of the advocates of a politically inspired program of nationalized medicine as a step in the transformation of the government into a socialist welfare state which brought charges of opposition to progress and to the best interests of the health of the nation's citizens.

In view of these false accusations, it seems timely to review those things to which we as physicians actually are opposed. Dr. Ernest E. Irons, immediate past president of the American Medical Association, recently summarized well the salient points of opposition. We are, said he,

Opposed to quackery, political as well as medical.

Opposed to trifling with human life by the use of dangerous quack remedies and to deceptive proposals of medical charlatans.

Opposed to trifling with human welfare by the promulgation of any so-called welfare measure which saps the vitality and incentive of citizens and ultimately leaves them enmeshed in the toils of socialism.

Opposed, both as physicians and citizens, to the imposition on the American people of a system of compulsory taxation to pay for a medical program which will destroy the quality of present medical care, and make impossible the remedying of recognized faults in our present system.

Opposed, in the same dual capacity, to the saddling on our national budget of an additional burden which will add to the present waste of our national financial resources, increase our taxes, and accelerate the progress of inflation.

Opposed, finally and most important of all, to the undermining of our American democracy by

the insidious propaganda of false security of the socialist welfare state.

With Dr. Irons, we are in accord with the statement of Benjamin Franklin: "Those who would give up essential liberty to purchase a little temporary safety, deserve neither liberty nor safety." The forthcoming advertising campaign in behalf of American medicine, although a radical departure from former policy, should go a long way toward revealing to the laity the true stand of the medical profession, dedicated unequivocally as it is to improvement of medical care for all the people.

Sanford B. Manks and the Germ Theory

Sanford B. Manks of DeLand, Florida sounds forth in the *Herald of Health and Naturopath Magazine* for July 1950 in an article called "Naturopathy Is the True Healing Method." Among the profound observations of this would-be oracle and healer was the statement that germs are secondary, that they are not the cause of disease but the result of it. The following paragraph preceded the article:

"As explained many times before, this author—although a Naturopath of country-wide standing—cannot receive mail at his home under his professional title. When letters do arrive in DeLand, Florida, addressed to Dr. Manks, they are returned by the post office to the sender. Our author is 'officially dead' because he dared defy medical might. But he's not discomfited as each and every day he is joined in this unique gehenna by other practitioners who have 'overstepped' the lines laid down by big hearted medical science."

Articles of Medical Interest in Lay Publications

It is gratifying to note the ever increasing number of well written articles of medical interest in outstanding lay publications throughout the nation. We have two in particular in mind at the present time: one in the July issue of *Red Book*, page 26, entitled "Is Your Doctor a Quack?" and the other in the July 8 issue of *The Saturday Evening Post*, page 30, entitled "The Man the Doctors Hate" (Oscar Ewing).

The *Journal* is devising a plan whereby every article of this type will be noted when it appears and a record made of it for future reference.

Hearings

Presidential Reorganization Plan No. 27—To create a Department of Health, Education and Security. Public hearings were held on July 6 and 7 by the Senate Committee on Expenditures in the Executive Departments. Dr. Louis H. Bauer, Chairman of the Board of Trustees, represented the American Medical Association. His testimony contained many of the same basic arguments used by him in testifying against the plan at the House of Representatives hearings in June. In addition, he was able to include the recent House of Delegates resolution "expressing its firm conviction that Reorganization Plan No. 27 will not promote the health of the people and will not effectuate the recommendations of American medicine toward that end." He further stated that this "plan does not reorganize anything. It merely elevates to an Executive Department status an existing agency of the Federal Government, with all of its inadequacies."

Other witnesses who testified against the Plan were Senators Taft, Hendrickson, Knowland, Butler, and Smith (N. J.); Marjorie Temple, American Association of University Women; Miles Kennedy, American Legion; and Edgar Fuller, American Association. Testifying for the Plan were Oscar Ewing and others.

The overwhelming defeat of the bill in the House on July 10 by a vote of 249 to 71, or 31 votes more than the majority of 218 necessary to defeat the Plan, appears to show that our legislators by and large agree with the philosophy of our medical leaders. Said Representative Arends (Ill.), Republican whip, aptly enough: "This is not even a reorganization plan. It reorganizes nothing. It would be much more accurate to call it a political promotion plan for the advancement of socialized medicine." All six of Florida's Congressmen were present and voted against the Plan. The profession would do well to commend them personally for their confidence in the free practice of American medicine.

1950 A.M.A. Convention

Evidence of the high interest the medical profession maintains in its professional organizations is manifest in the record breaking attendance at the recent 1950 A.M.A. convention in San Francisco. Although final tabulations are unavailable at this writing the preliminary estimates on registration indicate all old records have been exceeded by a large margin. The largest previous registration of

physicians was 15,667 at Atlantic City for the Centennial meeting in 1947.

Public interest in the activities of their doctors was equally keen as signified by unprecedented press coverage, local and network radio transmissions and telecasts. For the first time in history the address of the incoming president was broadcast over a nationwide network.

The scientific meetings contained papers of national and international significance. More than 300 papers were presented. In addition over 150 scientific and 300 technical exhibits provided valuable information to various phases of medical practice.

Dr. Elmer L. Henderson of Louisville, Kentucky, long associated with A.M.A. activities and chairman of its Board of Trustees at the time he became president-elect in 1949, succeeded Dr. Ernest E. Irons of Chicago as president. Dr. John W. Cline of San Francisco is the new president-elect. Dr. R. B. Robins of Camden, Arkansas, Democratic National Committeeman from his state, is the vice president. Among ranking officials re-elected to their respective positions were Dr. George F. Lull of Chicago, secretary and general manager, and Dr. F. F. Borzell of Philadelphia, Speaker of the House of Delegates.

Atlantic City was selected as the convention city for 1951. The Clinical Session, originally scheduled for Denver, Colorado, has been changed to Cleveland, Ohio, December 5-8.

Representing the Florida Medical Association at the San Francisco meeting were its two delegates, Dr. Homer L. Pearson, Jr., of Miami and Dr. Louis M. Orr, II, of Orlando. Dr. Pearson is a member of the Judicial Council. Dr. Orr served as a member of the House of Delegates Reference Committee on Hygiene and Public Health.

In spite of the great distance separating Florida from California 44 members of the Association are included on the official roster. They are:

BRADENTON: John F. Mason, William D. Sugg. COCOA: Thomas C. Kenaston. CORAL GABLES: William L. Wagener, Jr. DANIA: Fred E. Brammer. FT. LAUDERDALE: Alfred E. Cronkite, Garland M. Johnson, Richard A. Mills, Alva R. Taylor. JACKSONVILLE: William G. Harris, Gordon H. Ira, Wilson T. Sowder. LAKE LAND: James R. Boulware, Jr. MIAMI: James L. Anderson, Edward F. Fox, Robert M. Harris, Erna K. Klass, John D. Milton, Homer L. Pearson, Jr., Harold Rand, Wiley M. Sams, Robert T. Spicer, Richard F. Stover. MIAMI BEACH: Meyer J. Glick, Meyer B. Marks. MIAMI SPRINGS: Estella G. Norman. ORLANDO: Louis N. Christensen, Elwyn Evans, Edward T. Furey, Eugene L. Jewett, Louis M. Orr, II. ST. PETERSBURG: Dean W. Hart, Richard Reeser, Jr., Franklin W. Rousch, Jr. SARASOTA: J. Edward Harris,

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YOUR BLUE SHIELD

Blue Shield Reminders

Certain types of surgery require that individual consideration be given the claim for benefits before Blue Shield payment can be made. As cases of this nature are reviewed by the Blue Shield Claims Committee, it is necessary that certain medical information be submitted for a fair disposition of the claim. Some of the more frequent procedures requiring such information are listed below with reference to the additional information needed.

Hysterectomy

For surgery of the uterus, it is important to state whether a part or the entire uterus was removed. Florida Blue Shield's liability for a sub-total hysterectomy is \$100.00, whereas up to \$125.00 is allowed for total hysterectomy. When a sub-total is done in connection with gynecologic repair work, Blue Shield liability is \$135.00, and when the uterus is removed radically in connection with a cancerous condition the liability is \$150.00.

Appendix

When pathology of the appendix is the prime necessity for the operation, the fee allowed is \$100.00. When the removal of the appendix is incidental to other necessary surgery, no added liability may be accepted.

Burns, Lacerations and Plastic Surgery

In care of this nature, it is important that the area of the surface treated, length and depth of the wound, number of sutures required for closure, type of closure, area of skin grafted, etc. be indicated at the time the report is first submitted.

Reduction of Fractures or Dislocations

The Doctor's Service Report should indicate whether a closed or open reduction was performed and whether or not pins, plates, etc. were inserted.

Dermatology

The number, nature and location of all growths removed should be indicated on the claim report, as well as the type of closure, the approximate size of the growths removed and the number of sutures required for closure.

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Health Films Available to Physicians

Audio-visual aids are gaining rapidly in favor. One of the most popular is movies. Many schools and organizations now own film projectors. Professional societies clamor for technical films as an adjunct to regular programs. Such films frequently serve to stimulate better attendance. But many physicians do not realize that there is in the Florida State Board of Health a film library containing over 200 titles. These films are available without charge to any physician who requests them.

In these days of emphasis on public relations, many a busy doctor could use a popular health film to assist him in putting across a health program to civic clubs, women's groups or youth organizations. The State Board of Health has noted the rising interest in this form of education and has endeavored to keep abreast of the times by purchasing some of the excellent new titles released each year. High quality movies are produced by various commercial companies who have placed their films on loan in the State Board of Health Film Library. The only films accepted are those that conform to all ethical standards, as well as being interesting. Various voluntary organizations throughout the state, such as the Florida Tuberculosis and Health Association, have also deposited their films with the State Board of Health.

During 1949 3,300 films were shipped to various localities in Florida where they were seen by 800,000 persons.

Examples of professional films that physicians frequently request are: "Diagnosis of Breast Cancer," "Artificial Pneumothorax," "Diagnosis and Treatment of Venereal Diseases," etc.

Examples of popular films that physicians frequently use to supplement their talks before lay groups are: "The Traitor Within" (cancer), "Story of Wendy Hill" (diabetes), "Your Eyes," "Your Ears," etc.

A copy of a catalog may be obtained by writing to The Film Library, Florida State Board of Health, Jacksonville 1, Florida.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Armour, Thomas, Jr., Coral Gables
 Buchanan, Arthur P., Leesburg
 Crawford, Hugh, Daytona Beach
 Haskell, Edward G., Jr., Branford
 Moffett, James D., Jr., Daytona Beach
 Nickel, Frank W., Winter Park
 Smith, Clyde F. B., Miami Beach
 Sorvas, George P., Hollywood
 Starke, George H., (Col.) Sanford
 Sullivan, Benjamin H., Jacksonville
 Wickman, William, Miami

DEATHS

Deaths—Members

Alderson, Starling P., Miami June 29, 1950
 Russell, Ralph E., Ocala July 16, 1950

Deaths—Other Doctors

Stocking, John T., Jr. (Col.), Daytona Beach April 15, 1950
 Ryan, Maxwell D., Lake Wales June 11, 1950
 Maxwell, Leslie H., Ft. Lauderdale June 29, 1950
 Paniello, Santiago, Tampa July 5, 1950

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

Edward R. Annis, Miami, Robert Richter Amvets Post
 Jack O. W. Rash, Miami, Northeast Miami Junior Woman's Club
 Raymond M. Price, Ft. Lauderdale, local Kiwanis Club
 Edward R. Annis, Miami Acacia Club
 Harold S. Knowles, Orlando, local Kiwanis Club
 Kenneth Phillips, annual convention of Florida State Massage Association

STATE NEWS ITEMS

Dr. Walter C. Payne, Pensacola, immediate past president of the Association, has the distinction of being the first state medical association president to have his presidential address distributed throughout the country by the A.M.A. Public Relations Department.

Dr. Payne's address was sent as an enclosure with a recent issue of the A.M.A. "PR Doctor and Exchange." His address has brought several commendatory letters from throughout the country. Included among those sufficiently impressed to write to Dr. Payne are Mr. Lawrence W. Rember, assistant to the general manager of the A.M.A., who was present at the convention and heard Dr. Payne's address and Dr. E. O. Swartz, President-elect of the Ohio State Medical Association.

Drs. Jack Q. Cleveland of Coral Gables and Samuel W. Page, Jr., of Miami are attending a postgraduate program at Philadelphia sponsored by the American College of Physicians.

Dr. Robert T. Hyde, Jacksonville, was the guest speaker recently at a meeting of the local Kiwanis Club.

Dr. James R. Hanson has moved his offices from Wildwood to Tavares.

Dr. Walter W. Sackett, Jr., of Miami is in New York taking postgraduate work at Cornell University.

Drs. Albert V. Hardy, Phillip W. Horne, Floyd K. Hurt and Clarence M. Sharp of Jacksonville were members of the faculty of the Seminar on Tuberculosis which was held in Orlando recently.

Dr. Frederick H. Bowen of Jacksonville recently attended clinics and his class reunion at the University of Virginia Medical School.

WANTED—ASSISTANT TO GENERAL PRACTITIONER: Salary first year and percentage basis thereafter; Prefer a Gentile, Southerner, over thirty, and must have a Florida license; Write Nathaniel M. Weems, M.D., P. O. Box 578, Boynton Beach, Fla., giving full particulars.

Dr. Russell B. Carson has returned to his practice in Ft. Lauderdale following a trip to Puerto Rico. While in Puerto Rico, Dr. Carson attended the organizational meeting of the Puerto Rican Urological Society where he was invited to present a paper.

Dr. Edward G. Haskell, Jr., announces the opening of his offices in Branford.

Dr. Jack Galin of Jacksonville, after a lapse of five and one-half years in service and three years postgraduate residency training, has returned to his home in Jacksonville. Dr. Galin will limit his practice to urology.

Dr. Lloyd J. Netto of West Palm Beach was named physician for the Town of Palm Beach retirement fund system by the board of trustees at a recent meeting.

Dr. H. Milton Rogers of St. Petersburg recently addressed the medical staff of Bay Pines Hospital and members of the Hillsborough and Pinellas County Medical Societies on the subject of "Congenital Heart Disease."

Dr. Frederick K. Herpel, chairman of the Committee on Scientific Work, urges any member desiring a place on the scientific program at the annual meeting in Hollywood, April 23-25, to make application by November 1.

Applications, together with a brief synopsis of the paper, should be forwarded to Dr. Herpel at 223 Sunset Road, West Palm Beach.

Any specialty group having an outstanding essayist on its program preceding the Association's annual meeting is requested to make application for this essayist to read a paper of general interest before the scientific assembly.

Physicians who presented papers at the annual meeting in 1950 are not eligible for a place on the 1951 program.

Dr. Charles W. Boyd of Jacksonville recently lectured on internal and external diseases of the eye at Florida State University.

FOR SALE: Office space and equipment of a well established E.E.N.T. practice located in Ocala. Associated with five other doctors in modern office building. For details write: Mrs. Ralph E. Russell, 919 Lake Weir Avenue, Ocala, Florida.

Dr. John W. Hayes of Jacksonville addressed the Polio Workshop for nurses at Hope Haven Hospital in July on the subject of early diagnosis and treatment in acute anterior poliomyelitis. Dr. Frank L. Fort discussed orthopedic correction of deformities resulting from polio.

Drs. Arthur J. Butt, Jr., and Joseph Q. Perry of Pensacola were guest speakers at a recent monthly meeting of the Coffee, Geneva and Dale County Medical Societies in Geneva, Alabama, on the subject of "Urologic Problems in General Practice."

Dr. Henry C. Sweany of Chicago has been appointed chief medical director of all Florida State Tuberculosis Sanatoria.

Dr. C. L. Brumback, formerly of Oak Ridge, Tennessee, has been named the new county health director of Palm Beach County.

Dr. Russell L. Counts of Branford is serving a one year residency in the Erlanger Hospital in Chattanooga, Tennessee.

Dr. Cornelia M. Carithers of Jacksonville was guest speaker at a recent meeting of the Jacksonville Pilot Club.

Dr. Reidar Trygstad announces the opening of his offices in Naples.

Dr. Luther W. Holloway of Jacksonville was a faculty member for the Southern Pediatric Seminar which was held in Saluda, N. C., in July.

Plans are rapidly nearing completion for the annual medical district meetings which are scheduled for Oct. 30-Nov. 3. Northwest District A will meet in Marianna on Monday, October 30. Northeast District B will be held in Ocala Wednesday, November 1. Southwest District C is scheduled for Ft. Myers on Thursday, November 2. On Friday, November 3, Southeast District D will meet in West Palm Beach.

RADIOLOGIST SEEKS ASSOCIATION: With Hospital, Group, or other Radiologist. Board Diplomate, Diagnosis and Therapy. Age 35. American, Cornell Graduate, healthy, hard worker. Florida license. Write 69-33, P. O. Box 1018, Jacksonville, Fla.

COMPONENT SOCIETY NOTES**Bay**

At the recent meeting of the Bay County Medical Society, Dr. Arthur J. Butt, Jr., of Pensacola presented a paper on "The Clinical Significance of Hematuria."

Broward

State dues for 1950 have been paid by all members of the Broward County Medical Society.

Dade

The regular monthly meeting of the Dade County Medical Association was held at the Miami Woman's Club. Dr. Herman H. Gray presented a paper on "Diagnosis and Treatment of Leprosy," with kodachrome illustrations.

Leon-Gadsden-Liberty-Wakulla-Jefferson

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held its quarterly meeting at the Florida State Hospital. Papers on medical subjects were presented by Dr. Rudolph Bell of Thomasville, Ga., and Drs. Harold H. Ring and Oswald A. Holzer, members of the Florida State Hospital staff.

Monroe

The Monroe County Medical Society recently held a combined clinical-pathological meeting at the Monroe County Hospital. Guests were Dr. Alfred E. Cronkite, Ft. Lauderdale, and members of the U. S. Navy Medical Corps from the local bases.

St. Johns

According to Dr. Joseph A. Shelley, secretary, the St. Johns County Medical Society has gone on record as endorsing the establishment of a health unit in that county, provided that before its establishment adequate funds be made available for the full cost of care of indigent patients including hospitalization when necessary.

OBITUARIES**Leland Francis Carlton**

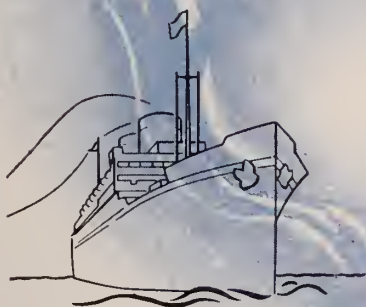
Dr. Leland F. Carlton of Tampa died on June 5, 1950 at the University Hospital in Chicago a few hours after he had undergone an operation. He was 62 years of age.

A Floridian, Dr. Carlton was born in Wauchula on Jan. 23, 1888. Upon graduation from the Wauchula High School, he attended Stetson University at DeLand for three years before entering the University of Chicago, from which he was graduated in 1909. He obtained his medical degree in 1914 from Rush Medical College in Chicago and then served an internship at the Washington Boulevard Hospital in that city.

Immediately thereafter, in 1915, Dr. Carlton entered the practice of medicine in Tampa. Although classified as a general surgeon, he specialized in orthopedic surgery. For thirty-five years he was active in civic and fraternal affairs of Tampa and Hillsborough County. He was a member of the Greater Tampa Chamber of Commerce, a past president of the Tampa Kiwanis Club and a past lieutenant governor of the fifth division of Kiwanis International. A thirty-second degree Mason and a Shriner, he was also a member of the Royal Order of Jesters, exclusive order of the Shrine. He was affiliated with the Knights of Pythias and held membership in the First Baptist Church of Tampa.

Throughout his career Dr. Carlton was prominently identified with numerous medical organizations. He was a member of the Hillsborough County Medical Society, of which he was a past president, the Florida Medical Association, the American Medical Association, the Southern Medical Association, the American College of Surgeons, the Southeastern Surgical Congress and the Founders' Group of the American Board of Surgery. In addition, he was a member and a past president of the Association of Seaboard Air Line Railway Surgeons, and of the Florida Railroad Surgeons Association. He was consulting surgeon to the Florida Workmen's Compensation Commission and surgeon of the Florida State Fair Association. For more than two decades Dr. Carlton served the Florida Medical Association as a member, and several times chairman, of important committees and in 1942 was Councilor for the Fifth District.

Continued on Page 169



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1. Council on Pharmacy & Chemistry: New and Non-official Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

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In 1921, Dr. Carlton married Miss Margaret Brown, daughter of former Mayor and Mrs. Charles H. Brown, of Tampa, who survives him. Also surviving are two daughters, Mrs. Herbert Kay of Wauchula and Mrs. Reid Gullatt of Cochran, Ga.; two granddaughters, Meg and Pamela Gullatt; two grandsons, Leland Carlton Kay and Stephen Kay; one sister, Mrs. Ella Southerland of Wauchula, and six brothers, former Governor Doyle E. Carlton of Tampa and Charles, C. J., Alton H., Gettis and Leffie M. Carlton all of Wauchula. His nephew, Dr. Leffie M. Carlton, Jr., of Tampa was associated with him in the practice of medicine.

George Walter Potter

Dr. G. Walter Potter of St. Augustine died on June 8, 1950 in a hospital in that city. He was 77 years of age.

A native of Pennsylvania, Dr. Potter was born in Bedford in 1873. He attended Franklin-Marshall Academy and Ohio Wesleyan University. In 1902, he received his medical degree from Jefferson Medical College of Philadelphia.

In 1908, he came to St. Augustine to reside and for thirty-seven years served on the medical staff of the Florida East Coast Hospital there, retiring in July of 1945. He was a past president and director of the St. Augustine Rotary Club, in which he was active for many years. He was a member of the Presbyterian Church in his home city and of the Masonic Lodge of Everett, Pa.

Dr. Potter was a member of the St. Johns County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are his widow, Mrs. Maude Potter; two daughters, Mrs. Edgar Austin and Mrs. Tim Merrill, both of Palatka; two sons, David W. Potter of Tallahassee and Samuel S. Potter of St. Augustine. Also surviving are a niece, Mrs. Carl Schuman of Osterburg, Pa., and four grandchildren.

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From where I sit by Joe Marsh

Mud Lake Gets "Cleared Up"

County officers got a notice from the government not long ago, asking them to change the name of Mud Lake. Seems it's a pond, not a lake, by government standards.

Because it lies inside our town limits, we asked to do the name-changing ourselves. Figured we'd think up a new name. Mud Lake's really not very muddy—sort of pretty, in fact.

County people said go ahead, so we held a Meeting. Everyone suggested something. Windy Taylor thought "Taylor Pond" would be nice, because his place borders it—for about 30 feet! But we decided to call it "Turtle Pond" in honor of the real owners.

From where I sit, naming that pond wasn't the most important thing in the world—but the way we did it was. Everyone offered his opinion and then the majority vote decided it. That's the way it should be—whether it concerns naming a pond, or having the right to enjoy a friendly glass of beer or ale—if and when we choose.

Joe Marsh

simplify the
mother's
problem

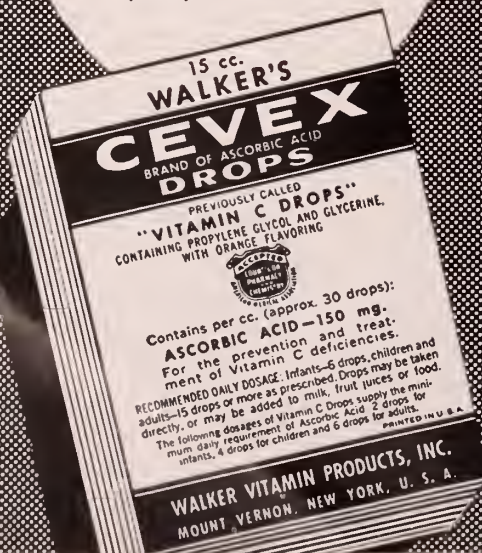
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What Every Doctor Should Know

One thousand, seven hundred and three doctors' wives registered at the 1950 convention in San Francisco this past June 25. These women did not attend the convention sessions because they enjoyed it more than anything else they could find to do in the city of San Francisco. They met together in order that they might be better fitted to carry on the work of the Auxiliary which is the number one ally to the American Medical Association. I only wish that a few of our Florida doctors could have "listened in" long enough to know exactly what the women are doing.

The national president, Mrs. David Allman, did not hold me to the usual two minute state reporting time since she wanted other states to hear something of what Florida had done in the Pepper-Smathers political campaign. I was delighted to have the extra time, so I "ad libbed" for six or seven minutes on what Florida Auxiliary members did as individual citizens in the recent political campaign. I suggested that they too should go home, take off their hats and gloves and get down to "grass root" politics and start clearing their termites out of Washington. I pointed out that women had a greater job to do than the men since most voters are women. The idea seemed to "take" for every delegate from Florida spent the remainder of her time in discussing ways and means citizens have to elect a candidate. Dr. Anderson and I spent two days in Salt Lake City on our way home, meeting with both doctors and Auxiliary members as well as candidates with the idea of giv-

ing them any advice we could on how they as citizens can help to defeat Senator Thomas of Utah.

Two very significant resolutions were passed in San Francisco: (1) that the Advisory Council of the AMA be petitioned to request that state auxiliaries stress within their respective communities the inclusion of the study of American History from the first grade through college, and (2) that the Auxiliary to the AMA implement the American Medical Association's twelve point program for the advancement of medicine and public health.

Florida now has sixteen organized county auxiliaries. We should have thirty-six in order to be 100 per cent organized. We need that organized force now more than ever before. Won't you give us a hand, boys? Please make it your personal responsibility to see that you have an auxiliary in your county, and that your wife is an active member. With our combined efforts this medical team will carry the ball which has been thrown to us for an American touchdown and victory.

Mrs. James L. Anderson
President

BOOKS RECEIVED

SEX WITHOUT FEAR. By S. A. Lewin, M.D., and John Gilmore, Ph.D. Price, \$3.00. Pp. 121. New York, Lear Publishers, 1950.

Made increasingly aware of the anxiety on the part of most young couples to build their married life on a firm foundation, the authors, after a careful survey of the available literature, prepared this little volume, couched in layman's terms, fully illustrated with simple but medically correct illustrations, with a comprehensive glossary and at a modest price, yet covering every necessary aspect of sex and sex relationships.

The book is addressed primarily to the young couple just starting married life. Its simplicity and clarity make it especially valuable, for it sets forth in simple, everyday language without technical or obscure phraseology, medically, psychologically and ethically correct information. Highlighting the text throughout are illustrations, both unique and vital, by Dr. Gilmore, well known medical artist.

The publisher points out that the book is being distributed ethically within the medical profession and its allied branches, and is available to the public on physician's prescription. It is intended as an aid in practice, covering every aspect of sex and sex relationships from genital anatomy to methods of contraception, and may be obtained by physicians at discount up to 50 per cent to enable them to keep sufficient books on hand to meet the immediate needs of their practice.

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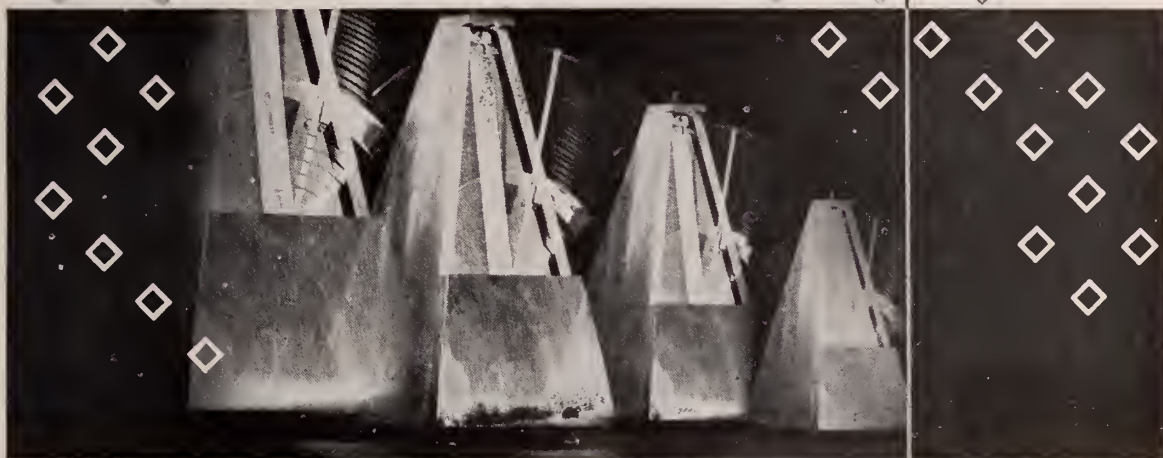
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GYNECOLOGY—Intensive Course, Two Weeks, starting September 25, October 23. Vaginal Approach to Pelvic Surgery, One Week, starting September 8, November 6.

OBSTETRICS—Intensive Course, Two Weeks, starting September 11, November 6.

MEDICINE—Intensive General Course, Two Weeks, starting October 2. Gastro-enterology, Two Weeks, starting October 16. Gastroscopy, Two Weeks, starting September 11, October 23. Electrocardiography & Heart Disease, Four Weeks, starting October 2.

DERMATOLOGY—Formal Course, Two Weeks, starting October 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting September 25. Cystoscopy, Ten Days Practical Course, every two weeks.

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1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. 209: 33-41 (Jan.) 1945.

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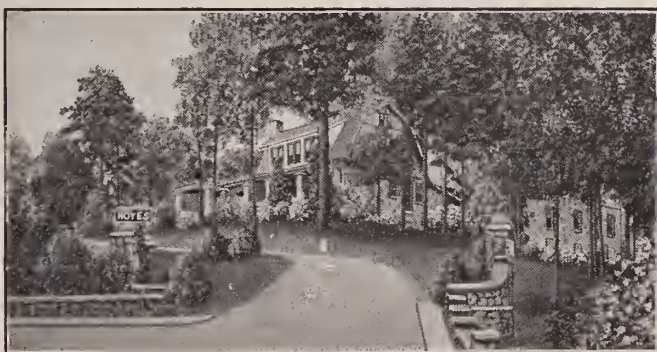
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Marianna, Oct. 30, 1950
B-Northeast	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	Ocala, Nov. 1, 1950
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Ft. Myers, Nov. 2, 1950
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	West Palm Beach, Nov. 3, '50
Florida Specialty Societies			
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	Hollywood, Apr. 22, '51
Anesthesiologists, Soc. of	Colquitt Pearson, Miami	Harold Carron, Tampa	" "
Chapter, Am. Acad. Gen. Prac.	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McEmore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	V. Marklin Johnson, W. Palm Beach	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" "
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 11, '50
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	November, 1950
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, Nov 26-28, '50
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Cleveland, Dec. 5-8, '50
Southern Medical Association	Hamilton W. McKay, Charlotte, N. C.	Mr. C. P. Loranz, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James M. Crews, Memphis	Mr. L. H. Gunter, Montgomery	
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	June McCafferty, Mobile, Ala.	Mobile, Ala.

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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Daniel M. Adams, Jr., M.D. Panama City Hospital Panama City	Jack Corbitt, M.D. Box 961 Panama City		17	16	
Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	72	67	
Franklin-Gulf	Donald H. Anderson, M.D. Wewahatchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	16	
Walton-Ocalaosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
Columbia Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	16	
Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	48	46	
Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	100%	
Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	3	
Taylor *Dicke-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	
						213

B

Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 825 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	43	42	
Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	245	233	
Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	27	100%	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	10	100%	
St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	18	100%	
Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	23	100%	
Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	138	132	
Seminole	Charles L. Park, M.D. 212 N. Park Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	13	100%	
Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	61	56	
						599

C

Hillsborough	David R. Murphy, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	155	147	
Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	100%	
Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	100%	
Pinellas	Albert R. Frederick, M.D. 116 4th Ave., N.E. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	171	169	
Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	38	100%	
DeSoto-Hardee- Highlands- Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	24	
Lee-Charlotte- Collier-Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	25	24	
Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	84	79	
						532

D

Indian River	Melton D. Council, M.D. Box 983 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	
Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	97	96	
St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	15	100%	
Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	75	100%	
Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	545	488	
Monroe	Herman K. Moore, M.D. 600 Elizabeth St. Key West	Allen S. Shepard, M.D. 403 Caroline St. Key West	2nd Thursday 8:00 P.M.	11	10	
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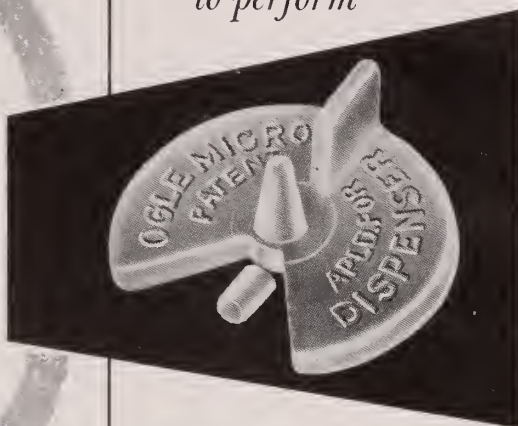
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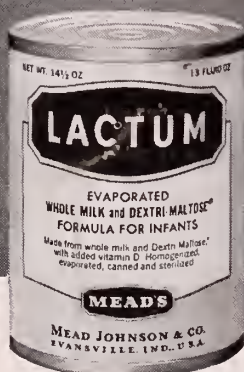
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OCTOBER, 1950

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Jack A. McKenzie
James J. Nugent



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OCTOBER, 1950

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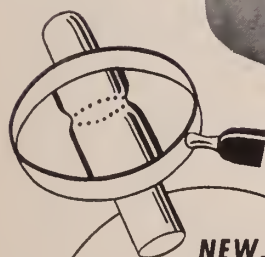
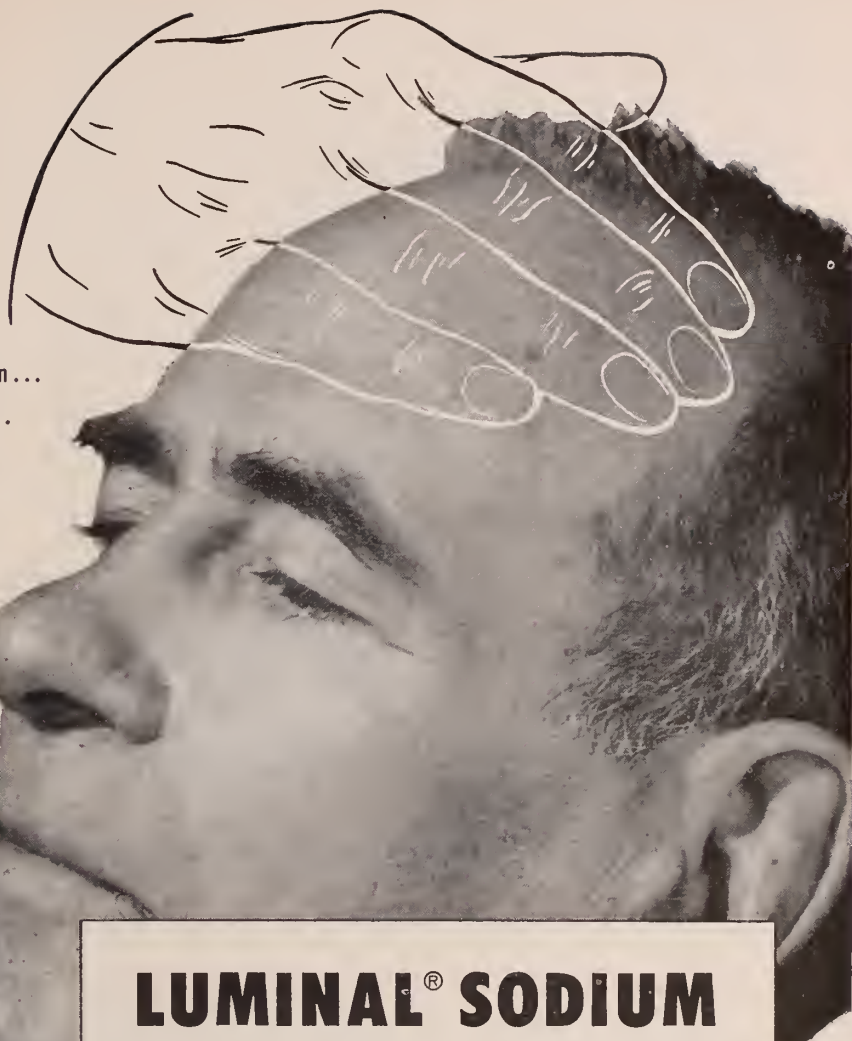
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—Luminal Sodium Powder is available in a new, constricted-neck ampul—serrated for easy opening. Only moderate pressure is required to make the file cut.

LUMINAL® SODIUM

BRAND OF PHENOBARBITAL SODIUM

Sedative... Hypnotic... Antispasmodic

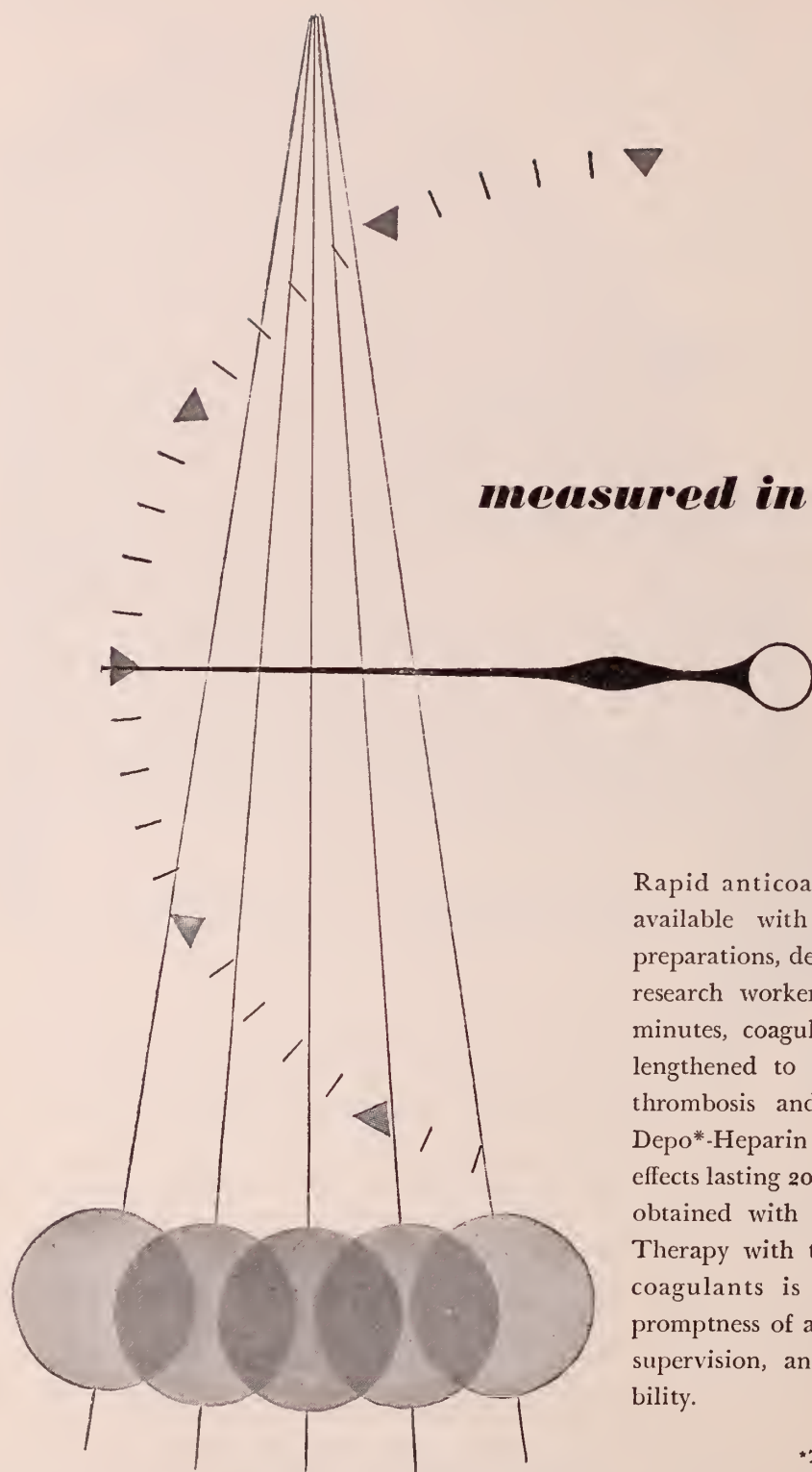
In conditions of excitement of the nervous system, as well as in certain spasmodic affections, Luminal Sodium acts as a soothing, quieting agent to tranquilize hyperexcitability or to curb convulsive paroxysms. Small doses have a pronounced sedative and antispasmodic action. Large doses are markedly hypnotic.

For oral use... tablets of 16 mg. ($\frac{1}{4}$ grain), 32 mg. ($\frac{1}{2}$ grain) and 0.1 Gm. (1 $\frac{1}{2}$ grains).

For parenteral use... solution in propylene glycol 0.32 Gm. (5 grains) in 2 cc. ampuls; powder 0.13 and 0.32 Gm. (2 and 5 grains) in ampuls.

Winthrop-Stearns INC.
NEW YORK, N. Y. WINDSOR, ONT.

Luminal, trademark reg. U. S. & Canada



measured in minutes

Rapid anticoagulant effects are available with Heparin Sodium preparations, developed by Upjohn research workers. In a matter of minutes, coagulation time can be lengthened to offset danger from thrombosis and embolism. With Depo*-Heparin Sodium, prolonged effects lasting 20 to 24 hours may be obtained with a single injection. Therapy with these Upjohn anticoagulants is distinguished by promptness of action, simplicity of supervision, and ready controllability.

**Trademark, Reg. U. S. Pat. Off.*

Upjohn

Medicine...Produced with care...Designed for health

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN

*"Oh sure...
it's
easy
for you
to
say*



*...but you aren't half-starved all the time like me...
since you put me on this reducing diet."*

The doctor who has to listen to such complaints certainly needs a "tin ear". Especially if he hasn't prescribed Efroxine Hydrochloride.

With Efroxine the patient won't complain of difficulty with the weight-reducing diet because Efroxine depresses the appetite so effectively.

Efroxine has a number of advantages over other sympathomimetic amines:
... It has a more rapid and longer-lasting effect with smaller dosage.
... It has little pressor effect in the recommended dosage range. This advantage is particularly valuable in the treatment of obesity.
... It increases the urge to activity with relative freedom from irritability and nervous tension.



Efroxine Hydrochloride *Tablets and Elixir*

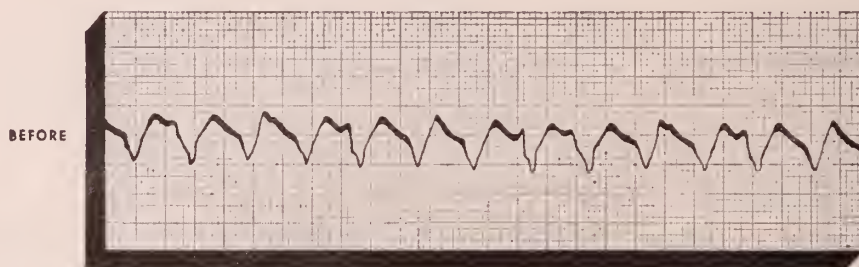
Maltbie Brand of Methamphetamine Hydrochloride

MALTBIE

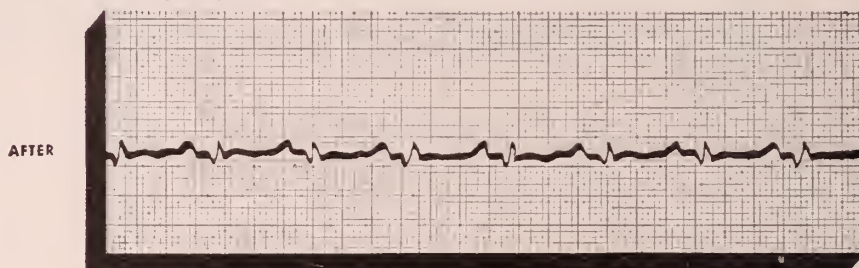


Laboratories, Inc., Newark 1, New Jersey

*A New Drug..*for the treatment of ventricular arrhythmias



Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).



Lead II. Normal sinus rhythm after oral Pronestyl therapy.

*Effective in some patients with ventricular
tachycardia who failed to respond to quinidine*

PRONESTYL *Hydrochloride*
Squibb Procaine Amide Hydrochloride
SQUIBB

"PRONESTYL" IS A TRADEMARK OF E. R. SQUIBB & SONS

new product brief

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride

for the treatment of ventricular arrhythmias

What is it?

Pronestyl Hydrochloride is Squibb procaine amide hydrochloride. Structurally, Pronestyl differs from procaine only by the presence of the amide grouping (CO.NH.) in Pronestyl where procaine has the ester grouping (CO.O.)

How does it act?

The action of Pronestyl is probably due to a direct depressant action on the ventricular muscle. In auricular arrhythmias, preliminary observations indicate that Pronestyl slows auricular rate but usually does not re-establish normal sinus rhythm. At present, Pronestyl is not recommended in the treatment of auricular arrhythmias.

When is it indicated?

In conscious patients, for the treatment of ventricular arrhythmias.

During anesthesia, to correct cardiac arrhythmias.

What are its advantages in ventricular arrhythmias?

As compared with quinidine: Unlike quinidine, no important toxic symptoms have been reported following the use of Pronestyl orally. In therapeutic dosage, Pronestyl orally does not produce the nausea, vomiting, and diarrhea often caused by quinidine. At high oral dosage, these symptoms may appear.

Whereas intravenous administration of quinidine is hazardous and unpredictable, Pronestyl may be given intravenously with relative safety.

Pronestyl has been found effective in some patients who failed to respond to quinidine.

As compared with procaine: For arrhythmias, procaine is used only in anesthetized patients because its dose in unanesthetized patients is too toxic for clinical use. Pronestyl can be used in conscious and anesthetized patients.

Intravenously, Pronestyl is much less toxic than procaine. In the recommended intravenous dosage, Pronestyl does not cause the central nervous system stimulation typical of procaine in conscious patients.

Procaine is unstable, being rapidly hydrolyzed in the plasma to para-aminobenzoic acid and diethylaminoethanol. Pronestyl is not affected by the plasma procaine esterase, consequently it is much longer acting than procaine.

Procaine is not used orally because of its instability in the organism; Pronestyl can be used orally and intravenously.

What are its side effects?

Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evi-

denced by studies of the blood count, urine, liver function, blood pressure, and electrocardiogram. Intravenous administration to patients without ventricular tachycardia produced only a moderate and transient hypotensive effect in about one-third of the subjects. However, during intravenous administration to patients with ventricular tachycardia, a striking hypotensive effect was almost invariably present. This disappeared concurrently with the establishment of a normal rhythm. Further studies are in progress to see whether the drug may be given intravenously over a period of time longer than five minutes so as to revert the ventricular tachycardia without causing hypotension. That this may be possible is indicated by the fact that some episodes of ventricular tachycardia have been successfully treated by oral administration without significant change in blood pressure. Electrocardiographic changes: prolongation of QRS and QT intervals and occasional diminution in voltage of QRS and T waves have occurred.

What is the dosage?

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia:

ORALLY: 1 Gm. followed by 0.5-1.0 Gm. every four to six hours as indicated.

INTRAVENOUSLY: 200-1000 mg. (2 to 10 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. If marked hypotension occurs, rate of injection should be slowed or stopped.

For the treatment of runs of ventricular extrasystoles:

ORALLY: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias:

INTRAVENOUSLY: 100-500 mg. (1 to 5 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

How is it supplied?

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.

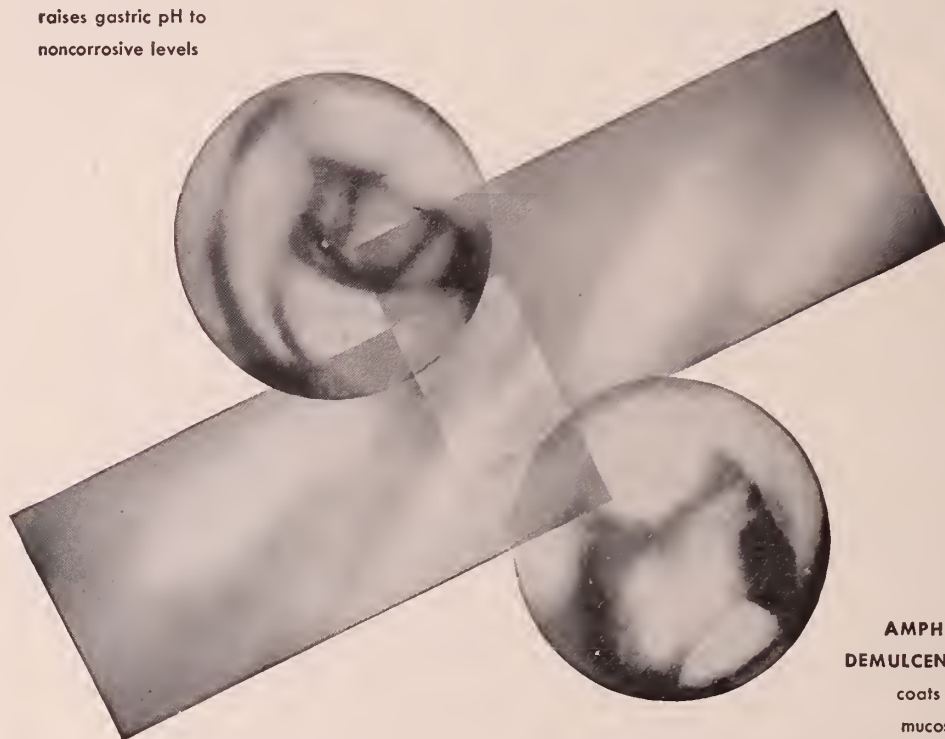
Pronestyl Hydrochloride Solution, 100 mg. per cc., in 10 cc. vials.



SQUIBB

**AMPHOJEL'S ANTACID GEL**

raises gastric pH to
noncorrosive levels

**AMPHOJEL'S
DEMULCENT GEL**

coats gastric
mucosa with
protective film

**double
protection**

For the Peptic Ulcer Patient

"Double gel" action

AMPHOJEL[®]

ALUMINUM HYDROXIDE GEL WYETH

Provides prompt relief... no alkalosis
or acid rebound. For sustained
benefit, prescribe AMPHOJEL LIQUID
for home and office therapy,
supplemented with AMPHOJEL TABLETS
for handy "between times" therapy.

LIQUID: Bottles of 12 fl. oz. **TABLETS:** 10 gr.,
boxes of 60; 5 gr., boxes of 30, bottles of 100

Wyeth Incorporated • Philadelphia 3, Pa.



**a
long
and
distinguished
career
in
urography**



NEO-IOPAX[®]

(brand of sodium iodomethamate)



An 18 year history of dependable roentgenograms obtained without harm to the patient distinguishes the career of NEO-IOPAX as a diagnostic urographic agent. Since 1932, *hundreds of thousands of doses* of NEO-IOPAX have been injected with virtual freedom from serious untoward reactions. No other urographic contrast medium has equalled the safety record of NEO-IOPAX. No agent, experience with which is limited to a relatively small number of patients, can be deemed to be as safe. Because the patient's life and welfare take precedence over all other considerations in diagnostic investigation of the urinary tract, urologists and roentgenologists will continue to rely—as always—on NEO-IOPAX.

Available as a stable, crystal-clear solution of disodium N-methyl-3, 5-diiodo-chelidamate in 10, 20 and 30 cc. ampuls of 50% concentration. NEO-IOPAX 75% concentration in 10 cc. ampuls, box of 5 ampuls; 20 cc. boxes of 1, 5 and 20 ampuls.

Schering

CORPORATION · BLOOMFIELD, NEW JERSEY

NEO-IOPAX



....In
Hypercholesterolemia

E L I X I R

Choline Chloride

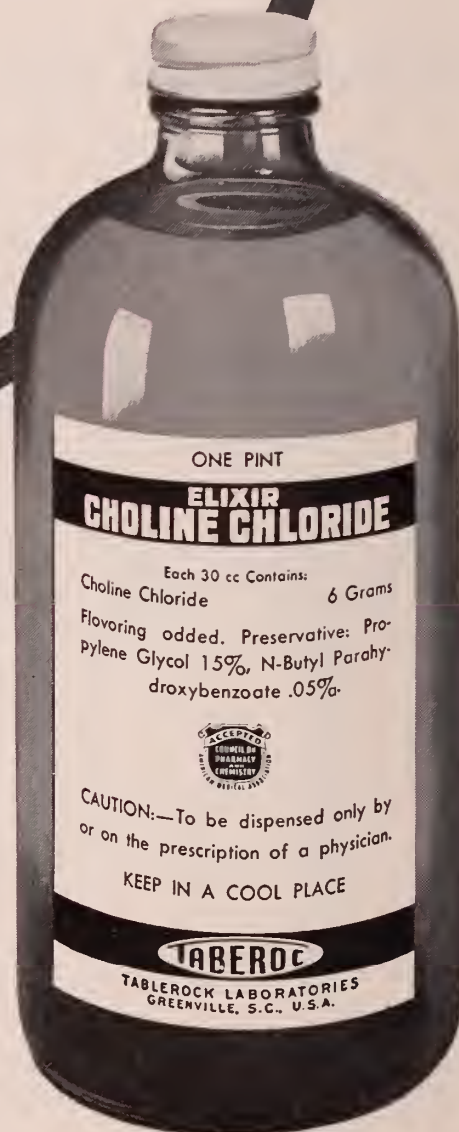
Choline is indicated in fatty infiltration of the liver associated with early cirrhosis, alcoholism, diabetes and malnutrition.

Each teaspoonful (5 cc) of Elixir Choline Chloride (Taberoc) supplies one gram choline chloride. It supplies more choline base than most preparations available for clinical use.

Elixir Choline Chloride (Taberoc) should be taken after meals and preferably mixed with half glass cold water.

Samples and Literature on Request

TABEROC



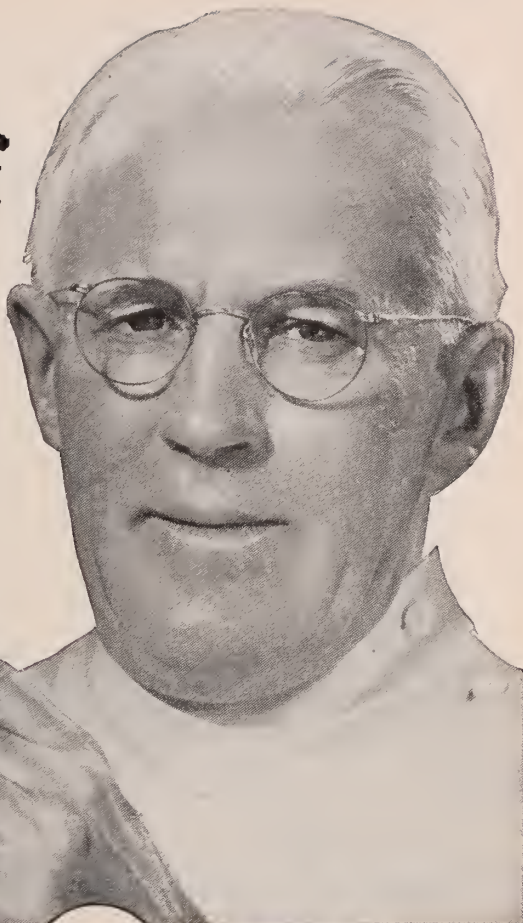
TABLEROCK LABORATORIES
GREENVILLE, SOUTH CAROLINA, U.S.A.

THROAT SPECIALISTS REPORT

ON 30-DAY TEST OF CAMEL SMOKERS...

“Not one single case of throat irritation due to smoking Camels!”

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.



I ENJOYED THE
TEST—EVERY PUFF OF IT!
AND MY DOCTOR'S
REPORT CONFIRMED WHAT
I FOUND—**CAMELS**
AGREE WITH MY
THROAT!

Ann O'Rourke
SECRETARY

R. J. Reynolds
Tobacco Co.,
Winston-Salem, N. C.

ACCORDING TO A NATIONWIDE SURVEY:

More Doctors Smoke Camels
THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.





PROVIDES PROTECTION WITHOUT IRRITATION

Evidence obtained by direct-color photography shows that the cervix remains occluded for as long as ten hours after an application of "RAMSES"* Vaginal Jelly.

"RAMSES" Vaginal Jelly immobilizes sperm in the fastest time recognized under the authoritative Brown and Gamble method of measuring the spermatocidal power of vaginal jellies or creams. This has been established by repeated tests for spermatocidal activity conducted by an accredited independent laboratory.

Clinical observation of patients receiving

daily applications of "RAMSES" Vaginal Jelly for three-week periods reveals no evidence of irritation or other untoward effect.

"RAMSES" Vaginal Jelly is acceptable to even the most fastidious patient because it provides efficient protection without leakage or excessive lubrication. It is available at all pharmacies in regular and large tubes; the regular tube is also available in a package containing a measured applicator.

ACTIVE INGREDIENTS: Dodecaethyleneglycol Monolaurate 5%, Boric Acid 1%, Alcohol 5%.



Julius Schmid, Inc.

gynecological division

423 West 55th Street, New York 19, N. Y.

quality first since 1883

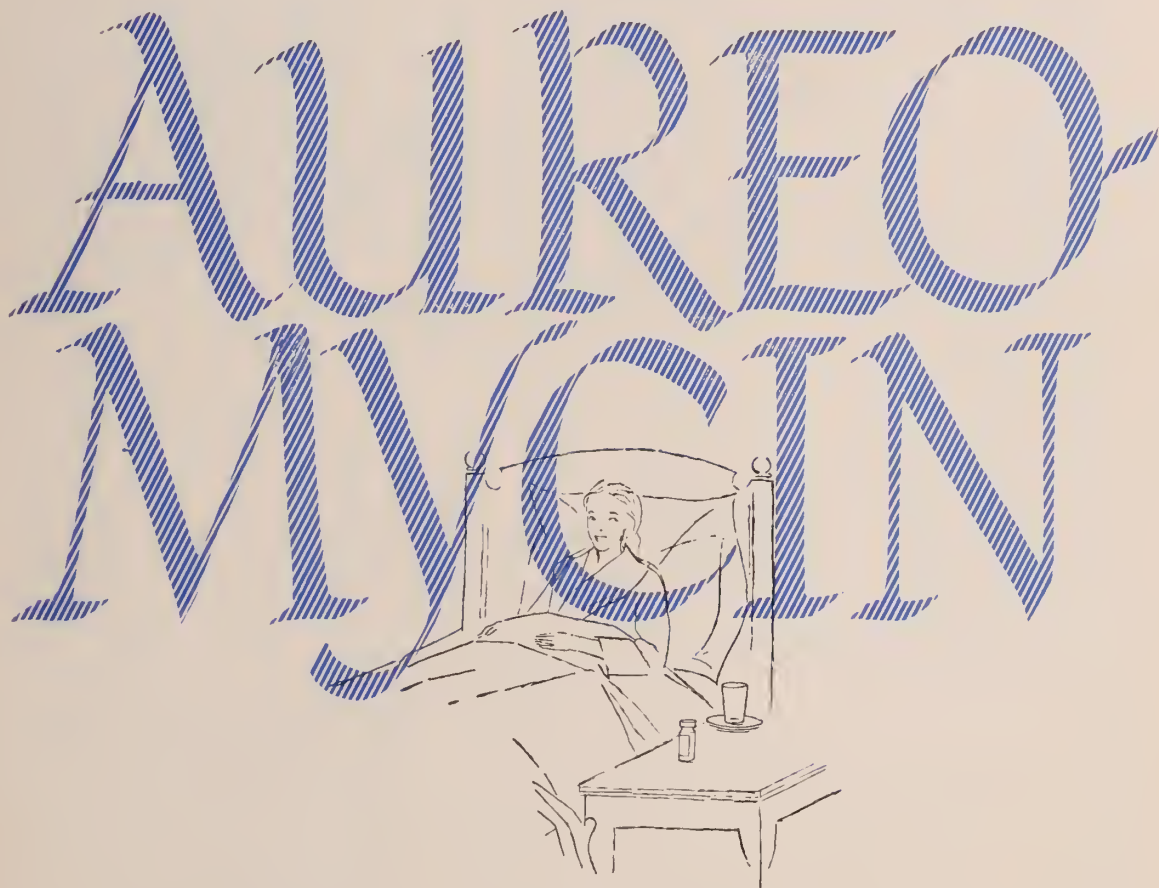
*The word "RAMSES" is a registered trademark of Julius Schmid, Inc.

AUREOMYCIN CRYSTALLINE

in Tularemia

Tularemia, which is a serious problem in many parts of this country, can be successfully treated with aureomycin.

All types of tularemic infection, with or without complications, respond promptly to the administration of this antibiotic.



AUREOMYCIN has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, common infections of the uterus and adnexa, resistant gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), and typhus.

Capsules: Bottles of 25, 50 mg. each capsule. Bottles of 16, 250 mg. each capsule.

Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

A urinary tract infection

Resistant to "... all available antibiotics and chemotherapeutic agents."¹

TREATED WITH TERRAMYCIN

M.F., male, age 48

History: Pyelonephritis, 1½ years' duration following ureterectomies; simultaneous implants (mixed infection: *P. vulgaris*, *E. coli*, *Staph. albus*, enterococci); previous therapy with all available antibiotics and chemotherapeutic agents without response.

Therapy: Terramycin, 2 Gm. daily for 5 days; orally in divided doses q. 6 h.

Result: Urine culture negative except for *P. vulgaris* by 2nd day of treatment. Response described as "good".

CRYSTALLINE Terramycin HYDROCHLORIDE

New Council-accepted broad-spectrum antibiotic
orally effective — well tolerated



1. Terramycin may be highly effective even when other antibiotics fail.¹
2. Terramycin may be well tolerated even when other antibiotics are not.²

suggested for: acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to *E. coli*, *A. aerogenes*, *Staphylococcus albus* or *aureus*, and other Terramycin-sensitive organisms; acute brucellosis (*abortus melitensis*, *suis*); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.

Dosage: 2 to 3 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.

Supplied: 250 mg. capsules, bottles of 16 and 100;
100 mg. capsules, bottles of 25;
50 mg. capsules, bottles of 25.

1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: *J. A. M. A.* 143:1 (May 6) 1950.

2. Herrell, W. E.; Heilman, F. E.; Wellman, W. E., and Bartholomew, L. A.: *Proc. Staff Meet. Mayo Clin.* 25:183 (Apr. 12) 1950

Pfizer

Antibiotic Division

CHAS. PFIZER & CO., INC., Brooklyn 6, N. Y.

REGARDLESS OF INDICATED THERAPY

Nutrition is a Primary Factor



Whether the condition under treatment is an acute infection, a bowel upset, an injury or a metabolic derangement, nutrition is always a primary factor in therapy. Regardless of other indicated measures, nutritional adequacy is essential for prompt recovery.

When dietary supplementation is the indicated means of increasing the nutrient intake, the food drink, Ovaltine in milk, can prove highly beneficial. Pro-

viding significant amounts of all nutrients considered essential, it virtually assures dietary adequacy when the recommended three glassfuls daily are taken in conjunction with even a fair diet.

Temptingly delicious and readily digested, this dietary supplement fits well into the framework of most indicated diets, and finds ready patient acceptance. Its generous nutrient content is detailed in the table below.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

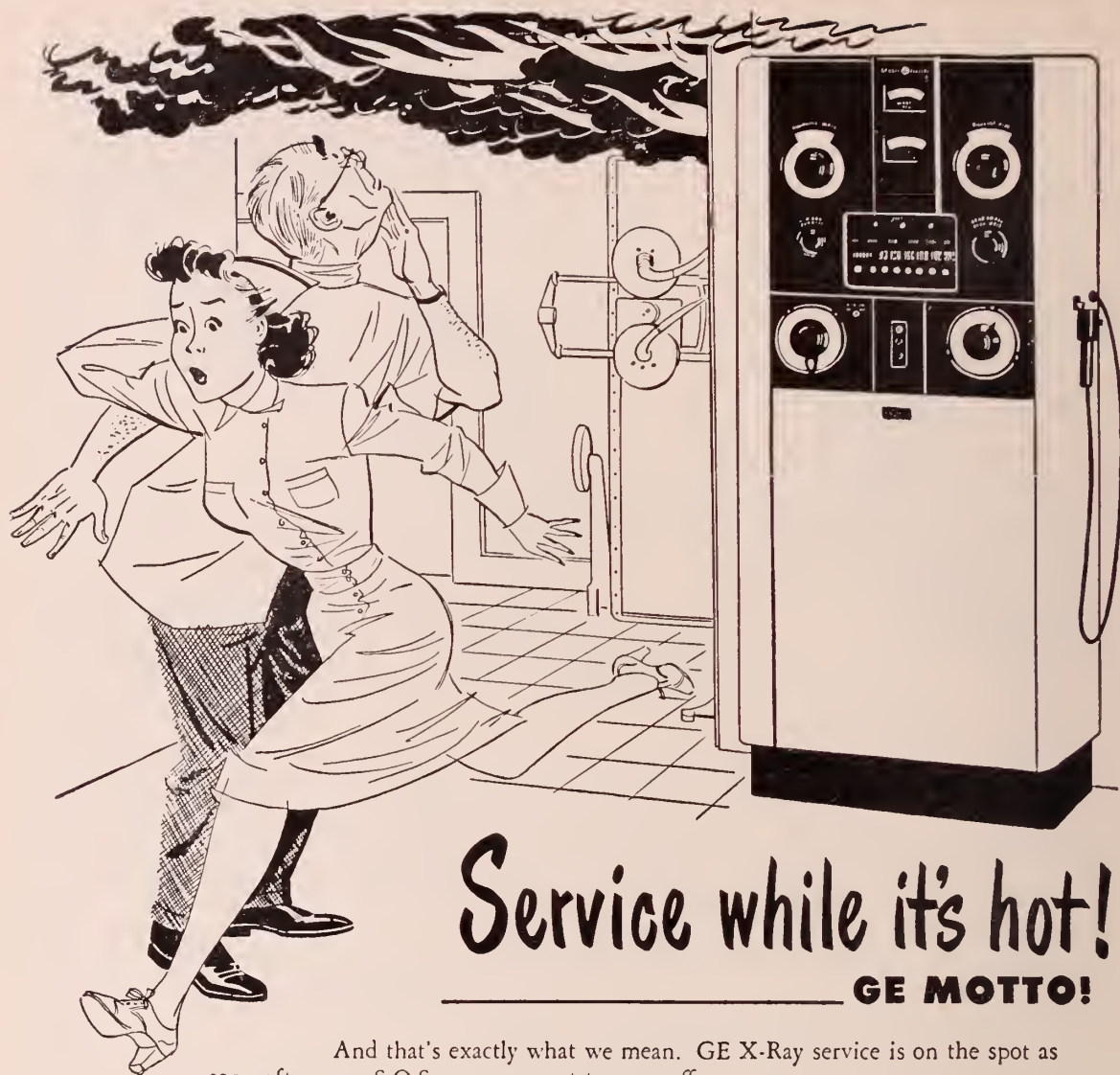
Three servings of Ovaltine, each made of
½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

PROTEIN	32 Gm.	VITAMIN A3000 I.U.
FAT	32 Gm.	VITAMIN B ₁116 mg.
CARBOHYDRATE	65 Gm.	RIBOFLAVIN	2.0 mg.
CALCIUM112 Gm.	NIACIN68 mg.
PHOSPHORUS094 Gm.	VITAMIN C30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.





Service while it's hot!

GE MOTTO!

And that's exactly what we mean. GE X-Ray service is on the spot as soon after your S O S as we can get to your office.

Take for instance the fire that put the x-ray department of a Long Island hospital out of commission . . . damaging beyond repair their diagnostic x-ray panel. Prepared for any contingency, the hospital pressed a mobile unit into action and called GE X-Ray service.

It took all night and two crews of servicemen to do it, but by dawn — the hospital's x-ray department was back in full operation.

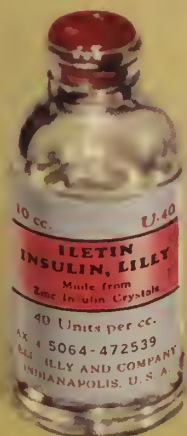
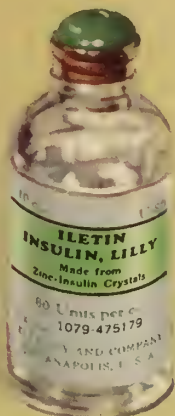
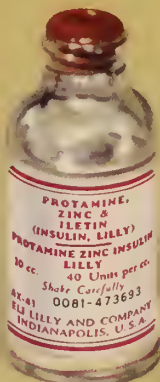
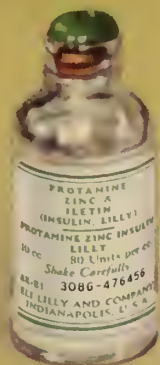
This story is typical of the hundreds of documented GE service reports in our files. A service which proudly lends a new, broader conception to the guarantee that stands back of every GE installation.

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no resting on old laurels

To secure the most normal life for the diabetic is ever the goal of Lilly research in diabetes. Iletin (Insulin, Lilly) was the first Insulin to be made available commercially in the United States. Although Lilly and Insulin have been intimately identified since 1922, Eli Lilly and Company has not been content to rest on its laurels; it has accepted the challenge and responsibility of seeking improvements. Wherever and whenever important developments are in progress, Eli Lilly and Company is usually an active participant. Medicine continues to look to Lilly for the latest improvements in diabetic therapy.

Lilly



Detailed information and literature on ILETIN (INSULIN, LILLY) are supplied through your M.S.R.*

*M.S.R.—Lilly Medical SERVICE Representative



A 19" x 12" reproduction of this illustration by Robert Riggs is available upon request.

bleaches it nearly as white as the surrounding snow; oriental seaweed then becomes commercial agar. This material is essential to the bacteriologist because it makes possible the preparation of pure bacterial cultures in solid media which do not melt during incubation. Used in both research and production, agar continues to assist the Lilly Laboratories in furnishing physicians with dependable biologicals.

harvesting seaweed for the laboratory

Kelp is first brought up from the bottom of the sea and then carried to a mountaintop in the process of becoming the "laboratory dining table" for germs. The cool air

Lilly

ELI LILLY AND COMPANY
INDIANAPOLIS 6
INDIANA, U.S.A.

Medical Planning for Atomic Disaster

COL. WILLIAM L. WILSON, MEDICAL CORPS,

UNITED STATES ARMY

WASHINGTON, D. C.

So much has already been said that it may be impossible to introduce many new thoughts concerning the atomic bomb. There have been numerous and widely published technical truths and half-truths, as well as perhaps excessive or unreasonable publicity. We physicians, therefore, are justified in recognizing some temporary pessimism until we confirm our capabilities for overcoming the hazards attributable to atomic bombing.

Effective Medical Planning

My objective shall be to point up the truths here and now. We should start with a determination to apply only that information we may obtain from recognized technical authorities. Thus prepared, we may support more confidently those administrative measures necessary to assure maximum survival along with minimum permanent damage to individuals and communities. Perhaps too few of us have done enough along that line. May we not increase our own and the public confidence by planned and organized activities of all of our health services, based upon simple detail and the means that will be available to us in the event of atomic disaster?

Medical planning for atomic disaster will have active public interest and support at all times if it is undertaken intelligently. At the same time we are attending to our own plans, we may stimulate that public support by proper publicity along the following lines:

We must justify the public confidence by consistent advance of our own knowledge of the organized response required for restoring or maintaining health in the event of atomic attacks.

We must impart the acquired facts to the people in understandable form to permit their active participation in our earliest medical planning.

We must conduct active educational programs which will tell all of the people what to expect if attacked, what to do and when, and how to do those things sure to benefit them and their health. As a result of effective medical planning along these lines interim periods of cold war, psychologic warfare before or during open hostilities, and active enemy attacks against our civilian communities should all be doomed to ultimate failure from their earliest inception.

It would be impossible to exaggerate the benefits guaranteed by public confidence that prompt and skilled medical services will be available at all times for repair of individual illness and injury brought on by war. It would be impracticable to visualize successful individual services without active methods of prevention and the maintenance of community health by competent health departments. It would be folly to pretend that atomic attacks would not devastate wide areas and could leave desolation where material, beauty, and human production once were evident. It would be futile to evade the fact that this bomb would kill, maim, and warp persons not fortunate enough to protect themselves adequately.

Explosion Hazards

The public has a right to and needs to know that the atomic bomb produces most of its damage, by far, exactly like previously known bombs. The two exceptions, and only two, are that the magnitude of the atomic bomb damage is far greater and that, to a limited degree, there is an added radiation effect. What the public will believe, as soon as their physicians and health departments tell them at every opportunity, is that valuable and available measures favor the survival of most of those resisting attack. Some of the measures will be precautionary, some restorative to meet the three hazards of blast, heat, and radiation. None of these three differs qualitatively

Special Assistant to The Surgeon General, Department of the Army.

Read before the Florida Medical Association, Seventy-Sixth Annual Meeting, Hollywood, April 25, 1950.

from the same hazards faced frequently by people who are not exposed to atomic bombing. Physicians and related health personnel already know these hazards. In addition, no one has as great access to individuals and families as physicians. They should, therefore, earn the full public confidence in advice and leadership in matters pertaining to their health under atomic attacks. Let us enlarge a bit upon some facts.

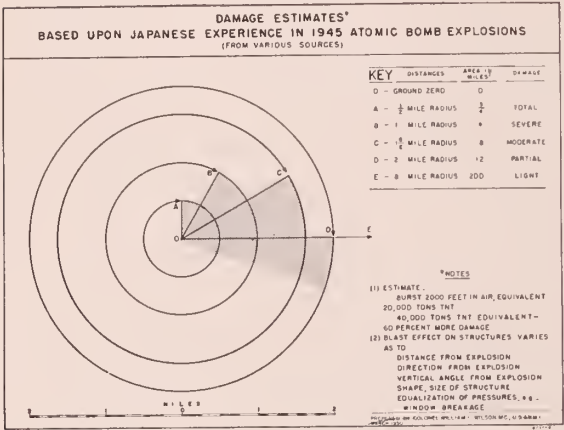


Figure 1—Table 1

The bomb is likely to explode in the air, but could land on the ground or in water. If it should explode in the air, the material damage would be similar to that listed in table 1,¹ presented diagrammatically in figure 1. The number of people surviving will increase from the center outwards. The fewest survivors will be found within one-half mile of the burst until we may have maximum and extensive precautionary measures not generally foreseeable. Casualties requiring medical services will be found mostly in a middle zone, neither centrally nor peripherally. The casualties would be produced in a manner indicated in table 2; if Japanese experience were applicable, 65 per cent would be due to blast, 20 per cent due to heat, and no more than 15 per cent due to all forms of radiation; perhaps only 1 per cent would be delayed radiation, most radiation hazard coming with the "flash." The medical nature of total casualties from one bomb has been well publicized,^{2,3} and variously estimated at perhaps 50,000 for an average American target area.

Public Responsibility

Three large groups of public responsibility exist for meeting these explosion hazards:

The first responsibilities, belonging to individuals, may be learned from table 3.

The second, belonging to medical and health services, constitute the subject of this paper.

The third group, belonging to local, state, and national governments, constitute the necessary organizing, administering, and supporting by logistic and other measures, of the efforts of individuals and all groups.

Individuals can meet their responsibilities only after we learn everything they need to know, then teach them. We must revise and add to these teachings whenever new knowledge is developed. In the other direction we must develop our medical plans at the same time we advise and aid in every practicable way the governmental efforts.

Medical plans for atomic warfare can be made relatively simple.⁴ Although there has been no fundamental change in the character of any of the essential medical services necessitated by atomic bombs, their management and implementation will require long and careful training of all participants. It should be comforting to know that a system which was adequate ten years ago⁵ will be just as satisfactory now if we provide for the greater magnitudes and the new problems of radiation. Plans will be required for three fields of health services, all integrated unto a uniform system:

AIR BURSTS OF ATOMIC BOMB		
WHAT HAPPENS		
EFFECT	EVIDENCE	WHAT TO DO
B L A S T	1 POSITIVE PHASE A PUSH OUT	1 DISPERSE IF WARNING IS GIVEN GET AWAY FROM POSSIBLE TARGET AREA AND AREAS THAT ARE BUILT UP REMEMBER THE FLYING DEBRIS
	2 NEGATIVE PHASE A SUCK IN	2 TAKE COVER AND STAY FOR ABOUT 30 SECONDS BASEMENTS, UNDERGROUND SHELTERS IF POSSIBLE GET CLOSE TO BASEMENT WALLS AND NEAR GOOD EXITS FROM BASEMENT AFTER BURST
H E A T	1 "FLASH" HEAT FLASH AT THE TIME OF BURST BURNS OCCUR OUT TO TWO MILES EASILY PROTECTED BY LIGHT CLOTHES OR ANY SWELEING SUBSTANCE	3 HELP OTHERS THOUSANDS OF LIVES CAN BE SAVED BY PROMPT AID HELP SAVE LIVES BY HELPING OTHERS 30 SECONDS AFTER BURST THE DEBRIS HAS STOPPED FALLING AND THERE IS NO RADIATION HAZARD
	2 SECONDARY FIRES STARTED BY STOVES, SHORT CIRCUITS AND THE LIKE CUT-OUT UTILITIES WILL PREVENT THESE FIRES	4 REPORT TO DESIGNATED PLACE ORGANIZATION IS NECESSARY TO REDUCE THE EFFECTS OF THE BOMB REPORT TO RECEIVE TREATMENT IF NECESSARY BE EVALUATED IF DESIRABLE AND TO WORK TO HELP OVERALL SITUATION
R A D I A T I O N	1 "FLASH" RADIATION GAMMA NEUTRON CANNOT SEE HEAR OR FEEL IT BUT IT IS THERE FOR A FLASH GAMMA RAYS ARE MOST PENETRATING AND LONGEST RANGE MORE HAZARDOUS BETWEEN YOU AND BLAST PROTECTS YOU MORE GAMMA DECREASES AS THE SQUARE OF THE DISTANCE FROM BURST	5 DON'T EAT OR DRINK OR SMOKE UNTIL TEARS ARE CHECKED OR CLEANED A SMALL AMOUNT OF RADIATION OUTSIDE THE BODY IS HARMLESS INSIDE THE BODY IT MAY CAUSE MUCH TROUBLE KEEP IT OUTSIDE
	2 LINGERING RADIATION ALPHA BETA SO SMALL IT IS NOT HAZARDOUS DISCARD IT	6 DON'T SPREAD RUMORS THINGS WILL BE TOLD ALL OVER KEEP YOUR EXPERIENCE TO YOURSELF AND DON'T ENLARGE ON WHAT YOU HEAR FROM OTHERS
		7 SCRUB DOWN & CHANGE CLOTHES AS SOON AS PRACTICABLE SCRUB DOWN AND CHANGE CLOTHES SCRUB HAIR FACE HANDS AND FINGERNAILS WELL

Table 2

Table 3

Medical and health services of truly essential nature required by communities with or without enemy attack.

Casualties services constituting medical care and therapy made necessary solely by enemy attack.

Public health services made additionally necessary solely by enemy attack.

In the matter of essential continuous services, additional concentration upon measures directed

toward preventive medicine, particularly sanitation, hygiene, epidemiology, and immunology, as well as towards increasing mental hygiene, will aid materially in meeting potential biologic hazards as well as psychologic warfare. It must be obvious that these would accompany or follow atomic explosions.

Any medical planning required for atomic warfare should be concentrated upon the administrative aspects, without which it would be impossible to apply economically and efficiently the available technical plans and knowledge pertaining to the subject. There should be plans for the casualties and public health services made necessary solely by enemy attacks. To repeat, this would be largely an administrative problem and must be directed at provisions for personnel, equipment and supplies, transport means, plant facilities, operational schemes, management, and their integration with other equally essential activities of nonmedical nature.

The treatments required by individual casualties surviving atomic explosion differ in no manner whatever from the best known treatments administered to patients currently by American physicians. Except for the vastly increased numbers, the medical profession has no newer or greater problem in treating atomic casualties than is faced daily in efforts to improve the quality of all techniques. The medical planning, therefore, must be directed towards treatment of thousands of patients suffering from blast, heat, and radiation.

Preventive Measures

We should digress at this point long enough to stress the enormous advantages of properly taught preventive measures. The public, the medical and health services, suppliers of material, industrial production, and prosecution of a war effort all depend upon success along this line. Known counter-measures to blast, heat, and radiation due to other causes than atomic explosion can be applied successfully, even if proportionately only, to minimize the personal effects of atomic explosion. We will never need to treat the casualty which was avoided by one's own efforts. If not avoided, we must treat each one. Our objective then must be diminishing numbers of casualties brought about by application of preventive medicine.

Medical experience must be applied to obtain intelligent avoidance of blast injury, limited at present to Japanese experience along a potential distribution of 50 to 60 per cent contusions, 30 to

40 per cent lacerations, and 7 to 15 per cent fractures. It is essential that we be prepared to revise our estimates as new experience dictates. What each person can do has been discussed by Gerstell⁶ in a recent popular article of real merit. The preferred procedure is orderly movement out of the target area; when impracticable to do that, the next best choice is the deepest and closest available foxhole, well covered over, of a type permitting later easy exit. The need for dispersion and distance can be applied to hazards of heat and radiation, as well as blast.

If sufficient cover against radiation is achieved, it will likely protect also from the blast and heat effects of an explosion. The greatest radiation hazard will be the gamma rays because of their large quantities and long range at the "flash" or

THE INFLUENCE OF DOSE-RATE
ON BIOLOGICAL EFFECT FOR EXTERNAL WHOLE BODY RADIATION
(FROM UNCLASSIFIED MATERIAL PROVIDED BY THE ARMED FORCES SPECIAL WEAPONS PROJECT)

DURATION OF EXPOSURE	50r ACCUMULATION	100 TO 300r ACCUMULATION	400r ACCUMULATION	500r ACCUMULATION
ONE MINUTE	LOWEST DOSE THAT WILL GIVE DETECTABLE EFFECT. (DROP IN WHITE BLOOD CELL COUNT) THE PATIENT FEELS NOTHING. (1)	AT 100r THE FIRST SYMPTOMS APPEAR 300r WILL INCAPACITATE A MAN FOR ABOUT SIX MONTHS. 200r - HOSPITAL PATIENT. (1)	THE 50% LETHAL DOSE - 1/2 OF ALL PERSONS RECEIVING THIS DOSE WILL DIE. (2)	100% LETHAL DOSE. (2)
24 HOURS	EFFECT REDUCED BY 50% - ONLY 1/2 WILL SHOW DROP IN WHITE BLOOD CELL COUNT (3)	EFFECT REDUCED BY 25% FROM ONE MINUTE EXPOSURE. (3)	EFFECT REDUCED BY 50% FROM ONE MINUTE EXPOSURE. (3)	EFFECT REDUCED BY 50% FROM ONE MINUTE EXPOSURE. (3)
30 DAYS	NO DETECTABLE EFFECT (4)	SLIGHT BLOOD CHANGES NO SYMPTOMS. (4)	SLIGHT BLOOD CHANGES NO SYMPTOMS. (4)	DEFINITE BLOOD CHANGES MILD NAUSEA. (4)
<div>1. - MEANS ROENTGENS</div> <div>2. WELL ESTABLISHED BY RESULTS ON HUMANS</div> <div>3. LESS CERTAIN EXTRAPOLATIONS FROM ANIMAL EXPERIMENTS.</div> <div>4. ESTIMATES.</div>				

Table 4

explosion of the bomb. While 1 inch of steel, 3 inches of concrete, or 4 inches of wood or earth will reduce the gamma intensity to half its initial amount,⁷ we must stress the enormous quantity which must be avoided or dissipated. It has already been indicated that other radiation hazards may be disregarded in the period immediately following explosion, at least until lingering or residual presence can be identified and measured by monitors. Although not universally agreed, the maximum daily allowable exposure to radiation has been set at 0.1 roentgen (or 0.1r — the quantity of X-radiation which on passing through 1 cc. of normal air produces 1 electrostatic unit of ions).² Table 4 demonstrates the influence of dose-rates on biologic effects from whole body radiation.

Treatment

It must be stressed that survivors of a blast who require treatment will need far more immedi-

ate attention to their lacerations and fractures and to a lesser degree their contusions than for radiation. The treatment technics are well established for these.

The greatest treatment problems likely would result from the large numbers and severe types of burns, particularly the "flash" burns in the event victims failed or were unable to take cover.² Almost all who need treatment will have burns. It is unnecessary to determine whether the burns are of "flash" or secondary flame origin as the pathology and treatment likely would be similar for all burns of equal degree. Of particular importance will be the rapid initial treatment, evacuation, and early definitive care for prevention of complications such as shock and infection. Technics and improved methods for handling these cases have been reported to be under careful and extensive study.

The treatments for radiation injuries, though relatively fewer than the others, may be complicated by the fact that in many such cases there will be burns also, the treatment for which may conflict with that for radiation.² We must await research successes to report the best general treatments in these cases.

The large quantities of dressings, antibiotics, blood, or blood derivatives and substitutes required for thermal and radiation casualties cannot be stressed too much. The pathology involved^{2,3,8,9} and treatments attempted to date are discussed in available pertinent publications.^{2,3}

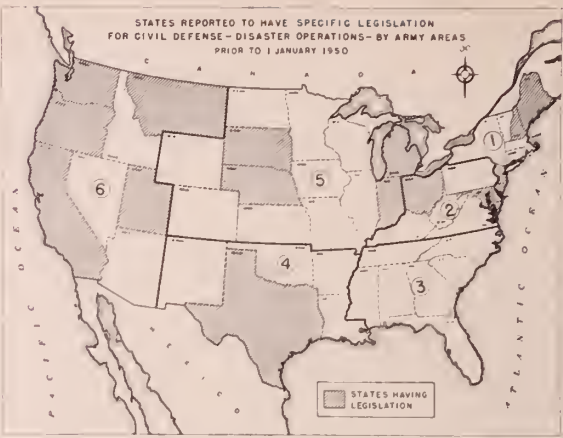


Figure 2

Community and State Plans

In view of the large volume of services required, special medical plans for every community will be necessary. Although they have been recorded elsewhere,^{4,10} the details deserve review at this time with a view to uniformity. Every community must do all it can for itself prior to receiving support and aid from others. Until every community has made its own plans and can be ready for its own problems, it would be unable to send support or aid to others with economy and efficiency. All of us may hope that every community likely to be called upon to render support to others, as well as every community likely to be a target of enemy attack, and every state, would do all possible to minimize the effects of atomic warfare. We should

RATIO OF POPULATION TO ONE PHYSICIAN
UNITED STATES — BY STATES

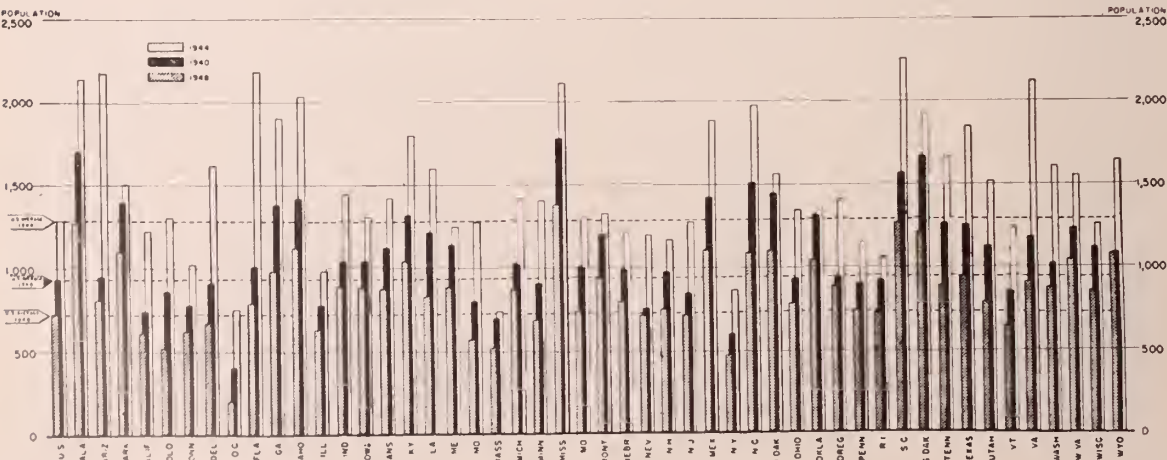


Figure 3

all see that the following are done by communities and states:

Plans are made and published
Available means are marshalled
Additional measures are undertaken, in the order listed:

Fixing responsibilities for activities involved
Establishing full authority for meeting each responsibility

Indexing responsibilities and authorities, divided into those currently existing and those not existing but required

Obtaining additional legislation or administrative acts required for (fig. 2):

Fixing responsibility
Prescribing authority
Providing means

Providing means by:

Survey of available resources
Determination of requirements of essential needs
Allocations of means to needs from available resources

Setting up a proper administration for:

Preparation and maintenance of plans

Budgeting, procurement, and disbursement of funds

Establishment of policies, procedures, training programs and guides, and operational systems

Activation of functional units

Procurement of personnel

Organization and training of units and individuals

Standardization for procurement, storage, issue and maintenance of physical means; plant facilities; equipment and supplies; transport

Establishing an adequate records and reporting system

Integrating civil and military plans and operations which can be assured by:

A simple classification of the adult population, so that we could assign all immediately to essential duties in emergencies¹¹

RATIO OF POPULATION TO ONE PHYSICIAN
UNITED STATES—BY CENSUS AREAS AND REGIONS*

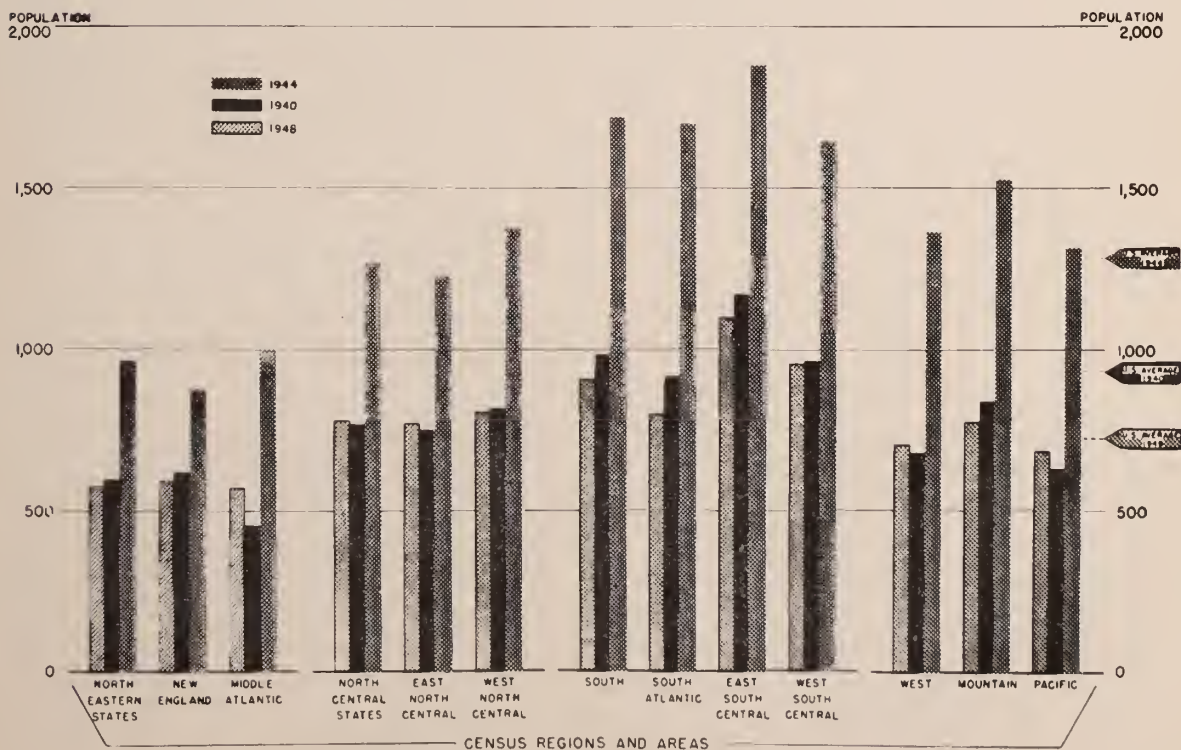


Figure 4

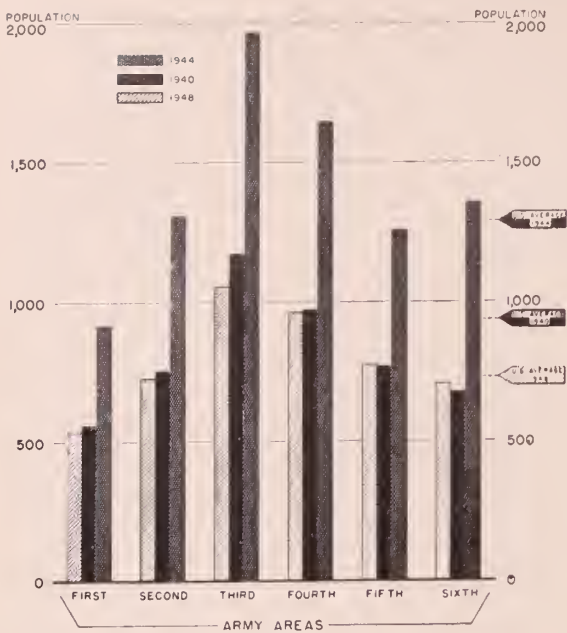


Figure 5

Development of standards of the minimum of health services that could be made to suffice during the emergency

Inventory of all civilian health resources

Obtaining uniformity in classification of health personnel and in their organization into units of a type which would be equally adjustable to civil or military administration in war-time; could be transferred from one control to another with facility, and could be utilized with economy and efficiency by either.

Indexing our aggregate medical and health resources (figs. 3-5).

Only by this means can we distribute our resources equitably and rapidly.

POTENTIAL SITUATIONS REQUIRING (INTERIM) MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

COMMUNITY OR PLACE OF DISASTER OR EVENT	COMMUNITY TO FURNISH INITIAL RELIEF HEALTH SERVICES	COMMUNITY REQUIRING SERVICES	SOURCE FOR ADDITIONAL HEALTH SERVICES WHEN OWN OVERWHELMED	COMMUNITY TO FURNISH TEAMS FOR SERVICES	COMMUNITY IN WHICH SERVICES MAY NEED TO BE PROVIDED
OWN ONLY	OWN	OWN ONLY	OWN EXPANDED OWN IMPROVISED ANOTHER COMMUNITY	OWN OWN OWN + OTHERS	OWN OWN OWN + OTHERS
ANOTHER ONLY	OTHER	OTHER ONLY	OTHER EXPANDED OTHER IMPROVISED OTHER + OURS	OTHER OTHER OTHER + OURS	OTHER OTHER + OWN OTHER + OWN
OWN & ANOTHER	OWN + OTHER	OWN + OTHER	OWN + OTHER EXPANDED OWN + OTHER IMPROVISED OWN + ALL OTHERS	OWN + OTHER OWN + OTHER OWN + ALL OTHERS	OWN + OTHER OWN + OTHER OWN + ALL OTHERS

Table 5

In addition to matters just mentioned, when requested to do so, military advisors should, as authorized, concentrate upon certain details of major importance to civilians undertaking civilian defense planning.⁴ The former may advise upon and stimulate the following:

The planning and establishment of simple civilian operational systems to include considerations of potential situations requiring (interim) medical plans for civil defense and disaster (table 5), possible situations (table 6), resources available (table 7), and those required to be preplanned and allocated (table 8); the services required (table 9), as well as special management problems (table 10); the zones of possible activity (table 11); we may aid in an inventory of personnel (table 12), as well as hospital beds (table 13), medical supplies (table 14), and medical transport (table 15); and we should help set up a local hospital plan (fig. 6), a local system of hospital evacuation for convalescent patients (fig. 7), and an evacuation scheme for all casualties (fig. 8).

Assurance that we obtain the necessary knowledge and administration to provide adequate nutrition under generalized disaster conditions in industry and in our public food planning for war.¹²

Maximum knowledge as to damage to be expected from atomic explosions (fig. 1).

Maximum attention to available references on the medical aspects of atomic weapons.

Maximum attention to possible defenses against psychologic,¹² biologic,^{13,14} and chemical warfare.

Regular review of plans and revision of plans and systems as populations move, cities develop, employment changes, and other changes occur.

Attention to sanitation,^{5,15} and the teaching of hygiene to all citizens. No single effort is likely to result in the greatest possible returns of civilian health so much as a population well informed in personal and community hygiene.

Preparation for handling of medical and other health problems related to migrations,¹⁶ evacuations,¹⁷ and resettlements or relocations.¹⁸

Repeating somewhat, insistence that every community, every hospital and school, every industrial or utility and service plant, every industry or corporation, and every state has:

Adopted a simple plan which is feasible, is understandable by all, and is adaptable

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED a CATEGORY OF EMPLOYMENT OF RESOURCES	
<u>CASUALTIES SERVICES</u> MEDICAL CARE AND THERAPY MADE NECESSARY SOLELY BY ENEMY ATTACK OR DISASTER SOME QUALITATIVE INCREASE OF NORMAL SERVICES, BUT PRIMARILY MASS TREATMENT INSTEAD OF INDIVIDUAL TREATMENT MUST BE ORGANIZED	<u>PREVENTIVE AND PUBLIC HEALTH SERVICES</u> MADE NECESSARY SOLELY BY ENEMY ATTACK OR DISASTER PRIMARILY QUANTITATIVE INCREASE OF NORMAL SERVICES, BUT MORE VIGILANCE SPEED IMPROVISATION MOBILITY SUSTAINED EFFORT COURAGE COMPLETELY ORGANIZED EPIDEMI- OLOGICAL SERVICE

Table 6

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED b CATEGORY OF SERVICES REQUIRED (UNITS & TEAMS TO BE ORGANIZED)	
<u>TREATMENT OF WOUNDS</u> ROUTINE - CLEANSING, ANTISEPSIS, ANTIBIOTICS, ANESTHESIA, ANALGESIA SHOCK - RESUSCITATION, MEDICATION, BLOOD OR BLOOD DERIVATIVES - OTHERS HEMORRHAGE - BLOOD & DERIVATIVES INFECTIONS - PROPHELYSIS - DEFINITE TREATMENT FRESH WOUNDS - IMMOBILIZATION, HEMOSTASIS, SUTURE - OTHERS BURNS - PHYSICAL, CHEMICAL, RADIOLOGICAL, (FLASH) MASS TREATMENT VASCULAR INJURIES - HEMOSTASIS, SUTURE, REPAIR NERVE BONE - JOINT ABDOMINAL - PELVIC CHEST - LUNG HEAD MAXILLO-FACIAL-ORBITAL	<u>TREATMENT OF CHEMICAL CASUALTIES</u> TREATMENT OF RADIOLOGICAL CASUALTIES TREATMENT OF NEURO-PSYCHIATRIC CASUALTIES <u>PREVENTIVE & THERAPEUTIC HANDLING OF CONTAMINATIONS & CONTAMINATED PERSONS</u> WHETHER CASUALTIES OR NOT RADIOLOGICAL, BACTERIAL & VIRAL, CHEMICAL EVACUATION - FIRST AID, AID STATION LITTER SQUADS AMBULANCE - DRIVERS, ATTENDANTS

Table 9

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(1) CATEGORY OF RESOURCES REQUIRED BY CIVIL DEFENSE AND DISASTER HEALTH SERVICES (EXCESS TO USUAL, NORMAL REQUIREMENTS)	
<ul style="list-style-type: none">• HOSPITAL FACILITIES• CONVALESCENT FACILITIES• PERSONNEL• TRANSPORT• MEDICAL SUPPLIES• BLOOD - BLOOD DERIVATIVES• MEDICAL EQUIPMENT	<ul style="list-style-type: none">• FOOD CLOTHING FEEDING SANITATION HYGIENE INSECT/RODENT CONTROLS OTHER NON-MEDICAL EQUIPMENT AND SUPPLIES• MEDICAL ADMINISTRATION MANAGEMENT FOR - DISASTER OR INCIDENT PERIOD

Table 7

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED c CATEGORY OF SPECIAL MANAGEMENT (FOR RESPONSE IN DISASTER OR ENEMY ATTACK)	
<u>HOSPITALS</u> <u>PREVENTIVE & PUBLIC HEALTH SERVICES</u> RECORDS & REPORTING SYSTEM (SPECIAL CASUALTY REPORTING) <u>MEDICAL REGULATING SERVICE</u> CONTROL OF PATIENT FLOW UNIT(TEAM) ORGANIZATION, TRAINING, EQUIPMENT, TESTING ALLOCATION & ASSIGNMENT OF UNITS AND INDIVIDUALS TO AT HOME { GEOGRAPHIC AREA OF CITY TYPE OF SERVICE TO PERFORM PLACE OF DUTY - EXACT PLACE OFFICE CONTROLLING THEM PERIODS OF DUTY AWAY - SUPPORT OTHER COMMUNITIES (AS ABOVE)	<u>ALLOCATION OF EQUIPMENT & SUPPLIES</u> PROCUREMENT, STORAGE, MAINTENANCE ISSUE AND DISTRIBUTION OF EQUIPMENT AND SUPPLIES PROVISION OF MEDICAL TRANSPORT CONTROL OF FLOW (REGULATING SERVICE) AMBULANCE VEHICLES SUPPLY VEHICLES PROVISION OF BLOOD & DERIVATIVES MASS HEALTH SERVICES - PREVENTIVE MEASURES, PARTICULARLY IN MASS EVACUATIONS, MIGRATIONS, WAR - DISPLACEMENTS

Table 10

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(1) CATEGORY OF RESOURCES REQUIRED BY CIVIL DEFENSE AND DISASTER HEALTH SERVICES (EXCESS TO USUAL, NORMAL REQUIREMENTS)	
(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED	
a CATEGORY OF EMPLOYMENT OF RESOURCES	
b CATEGORY OF SERVICES REQUIRED (UNITS & TEAMS TO BE ORGANIZED)	
c CATEGORY OF SPECIAL MANAGEMENT (FOR RESPONSE IN DISASTER OR ENEMY ATTACK)	
d ZONE OF ACTIVITY (FROM CENTER OUTWARDS - EVEN BEYOND CITY LIMITS)	

Table 8

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED d ZONE OF ACTIVITY (FROM CENTER OUTWARDS - EVEN BEYOND CITY LIMITS)	
INCIDENT----- COLLECTING----- EVACUATION----- HOSPITAL { INITIAL SELF-AID FIRST AID LITTER SQUAD COLLECTING-AID-POST AMBULANCE SECONDARY (CLEARING) HOSPITAL BASE (GENERAL) HOSPITAL	CONVALESCENT { CONVALESCENT HOSPITALS, HOMES RED CROSS OTHER COMMUNITIES OTHER STATES ARMED SERVICES OTHER

Table 11

to all other community, state, and national plans.⁵

Made sure that every possible participant understands his part and obligation under the plan.¹⁰

Limited every plan to resources, means, and operational possibilities likely to exist at the time of disaster.

Tested plans regularly by exercises and drills.

Summary

In summary, we have shown how medical plans for atomic disaster will benefit the nation; what the hazards would be; how individuals, communities, professions and governments all have positive responsibilities and capabilities for minimizing the effects of atomic explosion. Without underestimating the hazards, we have shown that the effects of atomic explosion can be minimized.

In brief, we have reviewed what happens, what to do, and in a limited degree how to do it. Each citizen becomes a key performer and the extent to which each practices the preventive medicine

SAMPLE INVENTORY OF MEDICAL SUPPLIES
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

LISTING BY ITEM REQUIRED	AVAILABLE AT ALL TIMES IN CITY	REQUIRED BY ZONE OF CITY				SHORTAGES BY ZONE OF CITY				SOURCES FOR MAKING UP SHORTAGES	TIME REQUIRED TO PROVIDE FOR SHORTAGES
		NW	NE	SE	SW	NW	NE	SE	SW		
BLOOD & DERIVATIVES											
DRUGS, BIOLOGICALS, PHARMACEUTICALS, ANTIBIOTICS											
SURGICAL DRESSINGS											
BANDAGES											
SURGICAL INSTRUMENTS, INSTRUMENT SETS, AID KITS											
SHOCK TEAM EQUIPMENT											
LABORATORY SUPPLIES											
DENTAL SUPPLIES (EMERGENCY)											
X-RAY SUPPLIES											
MISCELLANEOUS HOSPITAL AND MEDICAL SUPPLIES											
SANITATION SUPPLIES											
OTHERS											

Table 14

SAMPLE INVENTORY OF MEDICAL TRANSPORT
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

VEHICLES FOR MOVEMENT OF PATIENTS AND MEDICAL MATERIAL	NUMBER AVAILABLE AT ALL TIMES IN CITY	NUMBER REQUIRED BY ZONE OF CITY				SHORTAGES TO BE MADE UP BY ZONE OF CITY			
		NW	NE	SE	SW	NW	NE	SE	SW
TYPE OF VEHICLE									
MOTOR AMBULANCE									
MOTOR TRUCK									
VANS									
LARGE CARGO									
SMALL CARGO									
MOTOR BUS									
OTHER VEHICLES									
LITTERS									
BLANKETS									
SPLINTS AND VEHICLE AID KITS									

Table 15

SAMPLE INVENTORY OF PERSONNEL
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

MEDICAL PERSONNEL	IN PUBLIC HEALTH SERVICES	IN SCHOOL FACILITIES	UNAVAILABLE IN ARMED SERVICES RESERVES	AVAILABLE (LESS SPECIALISTS) (A) BY ZONE OF CITY (C)				NOTES
				NW	NE	SE	SW	
PHYSICIANS (A)								(A) DOES NOT INCLUDE SPECIALISTS CERTIFIED BY AMERICAN BOARDS THESE SHOULD BE LISTED SEPARATELY BY BOARD SPECIALTY AND BY SAME CATEGORIES AS SHOWN FOR PHYSICIANS TO PERMIT ALLOCATIONS TO DUTIES (B) INCLUDES— DENTAL LABORATORY DENTAL HYGIENIST HEAT & CARRY INSPECTION PHARMACY MEDICAL EQUIPMENT & MAINTENANCE VETERINARY ORTHOPEDIC MECHANIC OPTICIAN SURGERY ALL OTHER TECHNICIANS & TECHNICALLY TRAINED AIDES (C) WHERE EACH IS MAJOR PART OF EVERY DAY
DENTISTS								
NURSES—GRADUATE								
PHARMACISTS								
VETERINARIANS								
SANITARIANS								
DIETICIANS								
PHYSICAL THERAPISTS								
NURSES' AIDES								
PRACTICAL NURSES								
TRAINED ORDERLIES								
LABORATORY TECHNICIANS								
X-RAY TECHNICIANS								
OTHER TECHNICIANS (B)								
UNTRAINED ORDERLIES								
LABORERS								
NON-MEDICAL BUT ESSENTIAL PERSONNEL								
ADMINISTRATIVE								
HOUSEKEEPING								
ENGINEERING								
UTILITIES								
SERVICES								

Table 12

SAMPLE CITY
HOSPITAL BEDS FOR DISASTERS
IMMEDIATELY AVAILABLE

CTR OF CITY	HOSPITAL			NUMBER OF BEDS IN HOSPITALS—WITH ADEQUATE SPACE						NUMBER OF BEDS IN IMPROVED HOSPITALS	
	BASE (FULL SURGERY)	SECONDARY (CLEANINGS)	ADDRESS (STREETS & NUMBERS)	TOTAL WITH EMERGENCY BEDS	IN REGULAR DAILY USE	NOT IN REGULAR USE BUT READY FOR EMERGENCY		SOURCE OF EMERGENCY BEDS		NORMAL USE OF BEDS SPACE	SOURCE OF BEDS SPACE (CITY & STATE)
						IN HOSPITAL	ELSEWHERE	FROM HOSPITAL	OUTSIDE (SOURCES)		
NW	CITY	—	ST. THOMAS	1200	900	200	100	200	100		
	DOAKS	MERCY	ST. THOMAS	175	165	10	—	—	—		
	ST. THOMAS	—	ST. THOMAS	975	900	50	25	50	25		
	CHARITY	—	ST. THOMAS	200	175	20	5	20	5		
3150	(2)	(5)	ST. THOMAS	2700	2290	280	130	280	130	450	SCHOOL UNIV.
NE	WESLEY	—	ST. THOMAS	450	450	—	—	—	—		
450	(1)	—	—	450	450	—	—	—	—		
SE	NONE	NONE	—	—	—	—	—	—	—		
SW	MATEPITY	—	ST. THOMAS	75	70	5	—	5	—	700	UNIV.
775	(1)	(1)	—	75	70	5	—	5	—	700	
TOTAL	—	—	—	3225	2810	285	130	285	130	1150	

Table 13

we shall teach him for casualty avoidance will be a measure of his patriotic duty — a responsibility he has to himself, his community and his nation. Only the future can reveal the extent of catastrophe likely to result when people make no effort to save themselves. It has been characteristic of our medical profession, however, to accept no defeats, to know no fears, to withhold no service to victims of disaster.

The most critical test of our medical plans then will be the extent to which we shall attain all-round cooperation, performance by medical and health services under key staff members, but above all, our success or failure in maximum development and quality of the medical leadership available. With reasonable success in all of these, at least equal to that of the past, there could be nothing but triumph if we should ultimately be put to a critical test. If we should plan our future fully and never put the plans to test, there could be nothing but universal gratification.

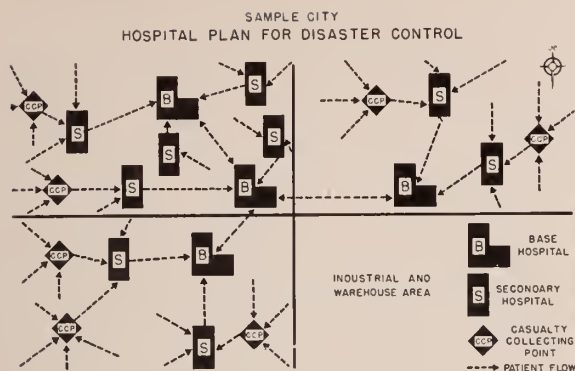


Figure 6

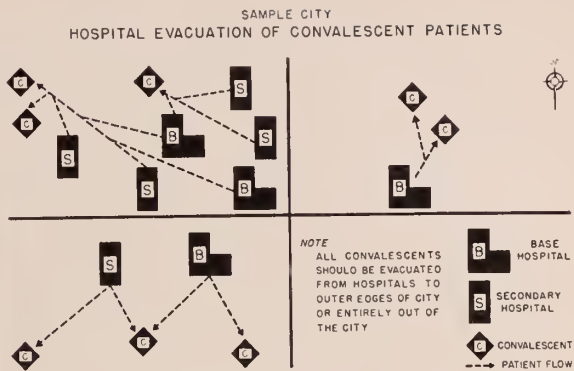


Figure 7

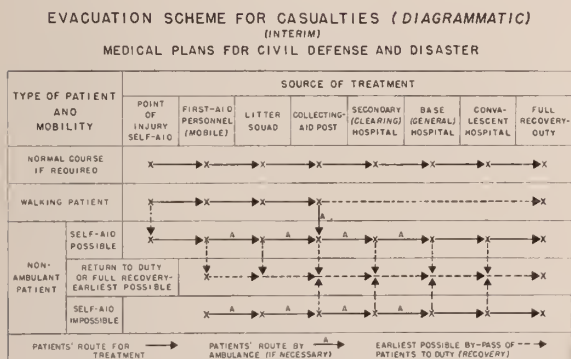


Figure 8

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Office of the Surgeon General.

Nummular Eczema, Its Differential Diagnosis and Treatment

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Literally, volumes have been written on the nummular eczemas of the hands. Various classifications, multiple diagnoses, diversified etiologic factors and a galaxy of treatment have characterized the discussions. I shall not bore you with references concerning these various works. It is not my purpose to present an entirely new aspect of this disease but merely to report on some of the clinical successes in long-standing cases. Since a large percentage of these eruptions have proved to be an allergic problem, I shall direct the chief portion of my discussion to that phase.

Classification

In order to discuss this subject intelligently, one must have some classification. I prefer to base this on etiology because successful treatment depends upon ascertaining the cause. There are various causes: (1) Allergies — (a) Food, (b) Inhalants, (c) Focal infection; (2) Contact — (a) Industrial, (b) Nonindustrial; (3) Infectious — (a) Fungus, (b) Bacterial; (4) Neurodermatitis; (5) Endocrine.

This brief classification includes all practical manifestations of this disease.

The chief etiologic factors of the nummular eczemas of the hands lie in the field of allergy. Of these, foods are the most frequent offenders.

These eczemas occur more frequently in women, in the ratio of approximately three to one. Their prevalence in both the North and the South is essentially the same. The common error, which is made by both the general practitioner and the dermatologist alike, is in the diagnosis of fungus infection and subsequent treatment with various fungicides and roentgen rays. Rarely is a case of nummular eczema of the hands proved due to a fungus infection.

The contact eczemas of the hands, both industrial and nonindustrial are rarely nummular in type but more frequently a diffuse, erythematovesicular eruption which essentially eliminates them from the category of nummular eczemas.

Those which lie in the infectious category consisting of, first, fungus infections, which are manifest by a squamous type of eruption occurring chiefly on the palms of the hands and which are characterized by central clearing and advancing vesicular border, and the bacterial infections, which are manifest by an acute inflammatory dermatitis in which miliary pustules are evident. The eruptions which are an allergic response to either of these infections, however, appear as the typical nummular eczema of the allergic type.

Neurodermatitis of the hands appears on the hands as elsewhere, namely, as a chronic lichenified dermatitis evidencing signs of excoriation.

The endocrine type of dermatitis may be in two forms. First, it may simulate neurodermatitis (perhaps it is one of the basic factors) occurring chiefly in women and is associated with clinical manifestations of gonadal dyscrasias. The second is the eruption which occurs on the palms and soles of both men and women in the postclimacteric period and is manifest by hyperkeratosis, scaling, mild pruritus and little underlying erythema.

Food Allergies

Fifty to 60 per cent of the nummular eczemas prove, in my experience, to be an allergic response. Of this group, fully three fourths are on the basis of food allergies. In the past ten years I have found that the following ten foods are of most importance — chocolate, nuts, tomatoes, spinach, asparagus, green beans, oranges, grapefruit, fresh pork and veal. The acidity or alkalinity of these foods does not seem to be of prime importance. Rather, it seems that there is a specific protein susceptibility. This is best exemplified by the fact that frequently a person may be sensitive to oranges or grapefruit, but lemons and limes are comparatively rare offenders. Also, odd as it may seem, the simple process of curing and smoking pork seems to change the protein sufficiently so that ham, bacon and other smoked pork products are not so common in their offense as the fresh, unadulterated pork. Other strange phenomena are noted such as: a person may drink canned

orange juice with impunity while the juice of fresh oranges may precipitate or prolong an eczema. Various simple industrial or household procedures may render various of the allergens impotent, such as is commonly observed in the eczema of the infant where, when the etiologic agent is cow's milk, the simple process of boiling the milk will eradicate the offender. These few examples will show the difficulties frequently encountered and how the ingenuity of the examining physician is often taxed.

The allergists, unfortunately, cannot give us the complete answer to this problem. Clinical trial and error is a necessity. So frequently patients give the history of having had allergy tests and having obtained positive reactions to a variety of foods; however, with the elimination of these foods, the eczema still persists in many instances. In such cases, when the patient is given a proper elimination diet regardless of the tested allergies, there may be prompt clinical response. Of course, the ideal way to test for food allergy would be to place the patient in a hospital. After a preliminary rice, salt and water diet lasting for five days or more, the process of adding one food every three days and noting its reaction would be the more exact. This, however, is not practical for a majority of people, and clinically we must choose the groups of food which are the more likely offenders. Hence the elaboration of the previously mentioned ten foods is at least a step in the right direction.

Psychosomatic Factor

In this group of eczemas, as in other allergic diseases, the unconscious nervous system plays a most important role. In other words, this is one of the excellent examples of psychosomatic disease. One example which will show the role which is played by the nervous system occurred during the recent war. A young married woman who had a typical nummular eczema of the hands which had existed for a period of four years, getting better and worse in spite of various forms of treatment, was examined. With the elimination of this group of foods and the administration of phenobarbital per os and a bland ointment locally, the eruption cleared entirely in a period of two weeks. With the resumption of the foods in an orderly manner, it was found by reprecipitation of the disease that she was sensitive to both chocolate and tomatoes. The elimination of these two offenders resulted in complete relief. Some months later, however, she reappeared at the office with her hands in the worst condition that they had

ever been. Neither one of the offenders had been indulged in. Her husband had been killed in the invasion of France, and a few hours after she had received the news, her hands erupted, becoming progressively worse. No therapy was instituted with the exception of the readministration of phenobarbital and the explanation to the patient that this was a psychosomatic response and that her hands would clear after her emotional upset had subsided. This happened. Many other similar cases have been observed but none so dramatic.

Therapeutic Regimen

The routine which has been elaborated is as follows:

The ten common offenders in all forms are completely eliminated from the patient's diet. Phenobarbital is given 1/4 grain three times daily before meals and at bedtime. If the eruption is weeping, either boric acid or saline soaks are used three times daily with some bland, drying preparation such as 10 per cent liquor carbonis detergens in calamine lotion to be used after soaking. If the eczema is squamous in character, a mild emollient such as 10 per cent liquor carbonis detergens in boric acid ointment is used. Depending upon the degree of itching, a suitable antipruritic is incorporated. The patient follows this procedure for a period of two weeks. If, when the patient returns, the eruption has subsided by as much as 50 or 60 per cent, the foods are added back in an orderly manner in an attempt to reproduce the eruption. During this trial period phenobarbital is administered routinely. It requires three days to test each food. The first day the food is administered three times at regularly spaced intervals; the second and third day is a waiting period because there may be either an immediate reaction occurring from fifteen minutes to several hours after ingestion of the first dose of food, so to speak, or it may be delayed as long as forty-eight hours after the last dose. If there is an allergic response manifested by erythema pruritus or vesiculation, this is considered as a reaction. It may vary in intensity with the individual. When this reaction occurs, there must be a suitable waiting period under the previous dietary regime. The patient must wait until the eruption clears before going on with the testing because any future reaction to other foods could be masked by the previous flare-up. If, however, after the two day waiting period there is no reaction, then the next food chosen may be tested. After such allergic responses have been ascertained, four weeks of com-

plete elimination of the offenders is necessary. If at the end of this time there is some residual eruption, mild roentgen therapy may be used on the hypothesis that such residual is due to a locus minoris resistentiae.

A certain percentage will not show improvement under such routine. The next procedure in these patients is the elimination of all wheat products, all milk products and sea foods. If, at the completion of the test with this group, results are still negative, I find it best then to start the patient on a basic diet beginning with such foods as beef, lamb and chicken, lettuce, turnips, carrots, Irish potatoes and cabbage. If improvement occurs with the use of this diet for a period of two weeks, addition of all of the other foods at three day intervals follows. If no improvement occurs; then an alternate similar diet containing none of these foods may be used as a basis; then, if no response occurs at the end of the two week period, the eruption may be regarded as nonallergic.

After the etiologic factors are determined, the eruption may persist as indolent areas of dermatitis. This continuation may be due to one of two factors. The first which must be considered is that these areas are merely areas of lichenification caused by the eruption having been there for such a long period of time. In these circumstances the use of roentgen therapy as well as tar, salicylic acid and other like therapeutic agents should be employed in order to eradicate this residual. The second factor which must be considered is that a combination of two or more foods may result in a mild allergic response, that is, neither carrots nor turnips alone would prove a causative factor but the ingestion of the two together would provoke a clinical reaction. This situation is difficult to deal with and demands close observation by the patient in order to determine what the factors are. Frequently, however, treatment such as is directed to the residual lichenification will often prove sufficient to eradicate the eruption without the necessity of determining these minor allergies.

Summary

To summarize, it is suggested that too frequently the diagnosis of fungus infection of the hands is made when a nummular eczema exists. A greater percentage of these eruptions is due to allergic responses, most of which are dietary. A practical regimen for determining such allergies is presented.

511 Harvey Building.

Discussion

DR. WILEY M. SAMS, Miami: In opening the discussion on this paper, I should like to begin by taking up the title of "eczema nummularis," or "nummular eczema." This, of course, is purely a morphologic diagnosis and was proposed by Devergie for a particular entity which he described many years ago, in which there were exudative small patches of eczematous dermatitis on the extensor surfaces of the arms and legs. Subsequently, similar lesions on the dorsa of the hands were likewise called nummular eczema. Now, nummular is derived from the diminutive Latin word "nummularis," which stems from "nummus," Latin for coin, and it means a little coin; it merely defines the size of the lesion. It has no other connotation. "Eczema" is from a Greek word "ekzeō," meaning "I boil over," and so an eruption which boils out in little, coin-sized areas is nummular eczema. An eruption on the hands which proves to be fungus, or contact in origin, or arises from contact irritation, I do not believe can be classified strictly as nummular eczema.

The attention directed toward foods as the cause of various types of eczematous dermatitis on the hands has been a continual one over a period of years. Since the close of the war, two excellent papers have been published by Flood and Perry, in which they designated recurrent vesicular eruptions of the hands as being caused in certain cases by allergy to foods. They carefully investigated a number of patients in Army hospitals during the war and subsequently hospitalized patients at the University of Pennsylvania hospital and presented an almost air-tight case for food as the etiologic factor in certain recurring eczemas of the vesicular type. Approximately two years later, Sutton published a paper in which he designated dry, lichenified, eczematous dermatitis of the hands as being related to food allergy. Many dermatologists, however, still accept nummular eczema as an enigmatic problem rather than an allergic one—in other words, one in which the etiology is still open to question.

In discussing the allergic background for an eczematous dermatitis, the patient always knows about food tests and he wants food tests. Unfortunately, the correlation between positive and negative reactions to tests of either scratch or intradermal type, and the recurrence of eczematous dermatitis, is small. The proof of the pudding is still in the eating, and it is well to bear that in mind. We can proceed by a trial diet in which, first, the patient is given nothing, or sugar and water, or perhaps one single food, and to this is added other foods, one by one, as we look for an exacerbation. We can furnish an elimination diet, such as Dr. Barney is offering, in which we eliminate common offenders—common offenders on the basis of previous experience by other clinicians. If the patient has only occasional flare-ups, we can ask him to keep a food diary and furnish us with the information which he accumulates preceding each recurrence.

I believe that success or failure in the management of the patient with this type of eczema depends almost entirely on how enthusiastic both the physician and patient can become in their method of investigation. A physician who is convinced that he knows the answer and can obtain it will inspire the patient. An inspired patient will cooperate. A patient who cooperates has an opportunity to learn. A patient can be trained to observe and be instructed, and then you have an opportunity, if both the patient and the physician are persistent.

I make only one plea for those who work on such problems. Retain a scientific attitude and insist on absolute proof by excluding the food, and by reintroduction, until it can be proved that recurrence is due to ingestion of any particular food.

Dr. Barney is to be commended for being one of those enthusiastic physicians who is willing to attempt to do more than carry out purely local treatment. He is making an attempt to work out some of the etiologic problems which underlie these stubborn, recurring, eczematous eruptions on the hands.

DR. BARNEY, concluding: I appreciate greatly Dr. Sams' scholarly discussion which has added a great deal to my remarks.

There is one thing, however, that I should like to stress and that is the psychosomatic aspect of this disease. When I first see these patients, I tell them never to forget the statement that this eruption is due to an imbalance of the underlying or unconscious nervous system, which often is affected by the conscious nervous system. So frequently they do, and I must remind them.

Evidently, the process which takes place is a depression of the level which allows these allergies to occur. All of us are familiar with the fluctuations which occur in this nervous system; that is, we have a minute by minute or hour by hour fluctuation, or perhaps it may be day by day. In addition, we are all familiar with the work by the various psychiatrists and psychologists which

proves that there is a period of depression in the unconscious nervous system, just as there is in the conscious, so that we may have this level at one time, one phase of the year, or perhaps in one month, and then we have depression of that nervous system. That explains why a patient may be allergic to tomatoes during February and March, but lo and behold, testing for them in January provokes no clinical response. It works out that way. It must be.

This is probably the most difficult disease with which the dermatologist and the general practitioner have to deal. Its various ramifications may be classified as the atopic dermatosis—as the atopic dermatosis of which probably the nummular eczemas of the hands are the most persistent problem.

I perhaps am too enthusiastic, but I wish that more of you would give more attention to the dietary aspect and less to the infectious aspect of this disease.

Problems Met in the Use of Dicumarol in Acute Myocardial Infarction

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The value of the anticoagulant drug, dicumarol, in the treatment of thromboembolic disease has been well established in the last few years. This is especially true in the prevention of thromboembolic complications in acute myocardial infarctions.^{1,2,3}

A good example of the effectiveness is shown in the study on the use of dicumarol in 800 cases of acute myocardial infarction, carried on under the auspices of the American Heart Association and the United States Public Health Service.³ This study showed that the use of dicumarol resulted in a reduction of deaths from 26 per cent to 14.9 per cent, and that the incidence of thromboembolic complications dropped from 36 per hundred in the control series to 14 per hundred.

With results such as these, it has become almost obligatory upon the physician treating acute coronary occlusion with myocardial infarction to use anticoagulant therapy, usually in the form of dicumarol.

There is not much dispute about dosage schedules for the use of the drug. The literature has many, but they are all about the same. After the preliminary doses of the drug, they all have as a basis a daily dose of dicumarol, the amount of which is determined by the prothrombin level. This is, of necessity, usually determined daily. The

method used in this determination is commonly the one stage Quick method or one of its modifications. A method in common use is the Link-Shapiro modification.

Prothrombin Activity Determination

While there is at present a question as to what constitutes the minimal effective prothrombin time, Wright⁴ stated that in his experience "the safe and therapeutic range is between 30 and 50 seconds by the Link-Shapiro method." This range, as interpreted in his laboratory, would approximate a prothrombin activity of between 20 per cent and 10 per cent. At the Mayo Clinic,⁵ it is believed that a prothrombin activity of between 10 per cent and 30 per cent is the most effective therapeutic range.

The determination of prothrombin activity is obtained in the following manner: A normal plasma, or normal pooled plasma, is used as a control. The prothrombin time is determined. This plasma is also diluted to 10 per cent, 20 per cent, and so forth, and the prothrombin times of these diluted plasmas are determined. The prothrombin time of the unknown is determined and compared with the resulting curve. The result is called the prothrombin activity of the unknown plasma, and it is expressed in terms of the dilution of the normal. By this method of determining prothrombin activity, the relationship between the prothrombin

time and the prothrombin activity expressed in percentage is a hyperbola.

Other methods of calculation are also used. Another common method, although it is one which may lead to considerable difficulty, is to determine the prothrombin percentage or clotting index. This is done using the formula

$$\frac{\text{control prothrombin time in seconds}}{\text{unknown prothrombin time in seconds}} \times 100.$$

The relationship between the prothrombin time and the clotting index is a curve which has no mathematical relationship to the hyperbola mentioned (fig. 1). The results obtained in this manner, therefore, cannot be compared satisfactorily with the therapeutic standards set up by using the other type of mathematical relationship.^{5,6}

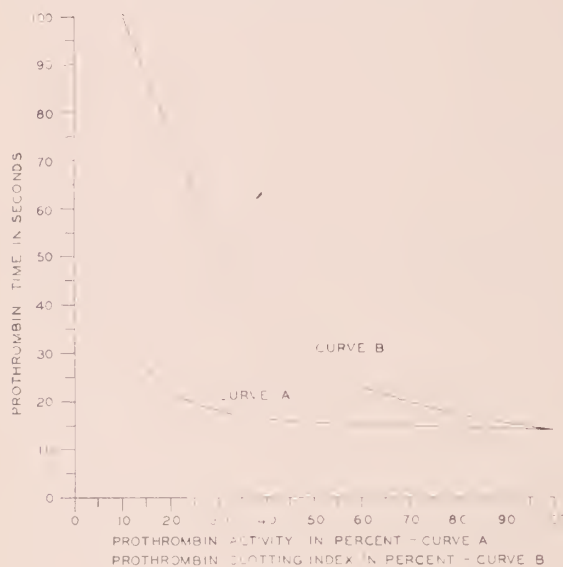


Figure 1

Difficulties Encountered

As noted, the literature is replete with glowing reports of the effectiveness of dicumarol therapy. In my attempts to employ the drug, starting in 1946, I found it difficult to use satisfactorily. I had considerable difficulty in maintaining prothrombin activity at the levels that the literature had pointed out were the proper therapeutic ones. I attempted to keep the levels between 10 per cent and 30 per cent, and as close to 20 per cent as possible, but I was unable to do this with any consistency. These same difficulties seemed to be encountered by others at our local hospitals, and led to the following survey to determine the nature of our difficulties more specifically.

A study of the use of dicumarol in 45 consecutive cases of acute coronary occlusion with myocar-

dial infarction was made. The patients in these 45 cases were treated by seventeen different physicians. They were all private patients and were treated between 1946 and early 1949, at either the Good Samaritan Hospital or St. Mary's Hospital in West Palm Beach. The amount of dicumarol given each patient for the most part was calculated on the basis of the day's prothrombin level. No case was included in which less than five determinations were obtained. The method used in determining the prothrombin level was the Link-Shapiro method. The results were reported in percentages. These were obtained by using the formula.

$$\frac{\text{control prothrombin time in seconds}}{\text{unknown prothrombin time in seconds}} \times 100.$$

Of the seventeen physicians who had cases in this series, using as a guide the reported literature, thirteen attempted to keep the prothrombin level under 30 per cent. They were unsuccessful, however, and were able to maneuver only a small percentage of the prothrombin determinations within what they thought were proper therapeutic levels. The most adept managed to keep 20 per cent of the determinations at the desired levels. Some were able to keep none of the levels in the range they desired. In 1 case, in which twenty-two determinations were performed, no determinations were kept between the desired 10 per cent and 30 per cent.

Of the four remaining physicians, three attempted to keep the levels below a reported 40 per cent. Their effectiveness of manipulation of prothrombin levels was greater, but the best that was done was the maintenance of 30 per cent of the determinations between the desired levels. The fourth attempted to keep the levels in his cases under a reported 50 per cent. He managed to get 46 per cent of his determinations within the desired range.

This inability to maintain what were thought to be proper therapeutic levels with any degree of consistency turned out to be most fortunate. Had they been maintained, the resulting prothrombin times would have been dangerously prolonged, and serious consequences would probably have ensued. The reason, of course, was the method of reporting the prothrombin levels.

As previously mentioned, the prothrombin levels were reported using the formula

$$\frac{\text{control prothrombin time in seconds}}{\text{unknown prothrombin time in seconds}} \times 100.$$

By using a control prothrombin time of fifteen seconds (most of the control plasmas used as a standard were within two seconds of this), the following results would have been obtained:

10 per cent	150	seconds
20 per cent	75	seconds
30 per cent	50	seconds
40 per cent	37.5	seconds
50 per cent	30	seconds

Since the safe and therapeutic range by the Link-Shapiro method is between thirty and fifty seconds,³ maintenance of levels between the reported 10 per cent and 30 per cent (150-50 seconds) for any length of time might have resulted in serious complications. That they did not occur was because the lower levels could not be maintained, despite efforts to maintain them. Only about 8 per cent of all the determinations, totaling 926, were in the range below 30 per cent (above 50 seconds), and less than 3 per cent were in the range below 20 per cent (above 75 seconds).

The reason why such dangerous levels were sought was, of course, because of a misunderstanding of the figures reported. The levels sought were those levels of prothrombin activity reported as the proper therapeutic ones in the literature. These were arrived at, as we noticed before, by the use of diluted plasma. The figures reported in these cases were therefore the result of an entirely different arithmetical process and could not be compared with those in the literature.

We have seen, therefore, how difficult it was in these 45 cases to maintain any particular set of prothrombin levels with any degree of certainty. The next problem is: How well protected were these patients by the dicumarol?

Again using fifteen seconds as the average normal plasma prothrombin time, and using the criteria of prothrombin times of 30-50 seconds as

the optimum therapeutic levels, we find that these correspond to reported levels of between 30 per cent and 50 per cent. Of all the determinations, totaling 926 in the 45 cases, 50 per cent were reported in this bracket and 42 per cent were reported above 50 per cent (or below 30 seconds). The remainder were below 30 per cent. In other words, during almost half the time that the dicumarol was being used, the prothrombin times were below thirty seconds, and probably not low enough to afford any significant degree of protection against further thromboembolic complications.

Summary

In a survey of 45 private cases of acute myocardial infarction in which seventeen different physicians used dicumarol in treatment, it was found (1) that there was a complete lack of understanding of the method used to report the prothrombin determination; (2) that the physicians using the drug had a great deal of difficulty in maintaining any particular set of prothrombin levels, and (3) that prothrombin levels indicating adequate protection against further thromboembolic disease were not maintained during almost half the time that the dicumarol was being administered.

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The Clinical Use of Terramycin in Infections of the Urinary Tract

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AND

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This paper is a report of the results of the use of terramycin in 41 cases of infections in the urinary tract.

Terramycin¹ is an antibiotic derived from *Streptomyces rimosus*. The drug has been synthesized, and adequate reports on its chemical and physical properties and laboratory in vitro and in vivo action have already been reported.^{2,3,4} Widespread investigation was made by a number of teams throughout the United States, and the results of the administration of terramycin in a variety of diseases are gradually appearing in the literature. The following report covers the results of investigation of the effect of terramycin on some diseases occurring in the urinary tract.

Methods

Diagnosis was established in all cases by the usual process of history, physical examination, and chemical and microscopic examination of the urine and of prostatic and urethral secretions. In addition, in 20 cases, identification of bacteria was made by cultural methods. Determination of sensitivity to terramycin was not carried out in any instances.

Determination of the effect of the drug was based upon microscopic examination of the particular secretion in all instances and, in 20 cases, by cultural methods. The criterion for cure required the complete absence of white blood cells, red blood cells and bacteria on microscopic examination and/or absence of growth on culture. In addition, in urethral infections, we required an absence of urethral discharge to the satisfaction of the patient and, in all cases, cessation of symptoms due to infection.

During the time that the patient was taking terramycin, no other drugs having antibiotic properties were administered. When indicated, suitable drugs for the control of other conditions or symptoms may have been administered concurrently with terramycin.

Table 1 shows the data necessary to evaluate the effect of terramycin in 41 cases of infections in the urinary tract.

Dosage

We establish as a standard a dosage of 2 Gm. the first day, 1.5 Gm. the second day, and 1 Gm. daily thereafter. In administration, the patient was given the following instructions: 2 capsules every six hours for four doses, 2 capsules every eight hours for three doses, 1 capsule every six hours until the supply is exhausted.

Most of the patients received about 7 Gm. of terramycin usually over a period of three or four days. The total amount varied from 1 Gm., which was used as prophylaxis after cystoscopy, et cetera, to 20 Gm., which was the largest amount that was administered to any one patient. The total dosage was determined to some extent by the limitation in the supply of the drug or money. In those cases in which there was proof of cure on smaller doses, it was considered that dosage was adequate. Since our supply of the drug was limited, it is possible that in some of the cases the patient received an inadequate total amount of the drug and an inadequate concentration at any given time. We have no proof that larger doses might not have eradicated infections which persisted.

Reactions

There were no serious reactions. Almost all patients recognized that the stools became somewhat looser. In the majority of cases, the patients were satisfied with soft adequate bowel movements. Several patients had rather loose stools to the point of watery diarrhea, and 1 patient found the diarrhea so distressing that it was necessary to discontinue the drug. Usually, the looseness of the stools was present for less than forty-eight hours. This reaction was not considered to be toxic and was an indication to discontinue the drug in only one instance.

Table 1. — Results of Terramycin Therapy in 41 Cases of Infection of the Urinary Tract

Patient	Age	Sex	Clinical Diagnosis	Culture and/or Stain Results	Amount of Terramycin in Grams	Other Drugs Used Before Terramycin	Ill Effects from Terramycin	Results
A. V.	52	M	Chronic Prostatitis	Hemolytic Staph. aureus.	11.5	None.	None.	Prostatic secretion free of w.b.c. Culture - B. proteus.
J. W. S.	69	M	Benign prostatic hypertrophy. Chronic prostatitis. Cystitis with 5 oz. residual urine.	Str. viridans, B. coli communis.	12.0	Penicillin, aureomycin.	None.	Excellent. Urine normal. Prostate still infected. Culture - B. proteus.
G. B. H.	63	M	Persistent infection after trans-urethral resection. Bladder diverticula.	Hemolytic streptococcus.	22.0	Sulfonamides, penicillin, mandelic acid, dihydrostreptomycin.	None.	Culture sterile. Cured.
A. B.	27	M	Bilateral polycystic kidney disease. Chronic pyelonephritis.	Staph. aureus.	9.5	Sulfonamides, streptomycin, mandelic acid.	Nausea, vomiting, diarrhea on 3rd and 4th days.	Poor. Culture - Staph. aureus.
M. R. H.	43	M	Mild chronic prostatitis. Urethritis, chronic, nonspecific.	Staph. aureus.	16.0	Local treatment.	Three soft stools on 2nd day.	Excellent. Urethritis subsided. Prostatitis persisted. Culture - Staph. aureus.
J. S.	53	M	Chronic anterior urethritis.	Negative.	16.5	Penicillin, streptomycin, aureomycin.	None.	No change.
C. F.	55	M	Squamous cell carcinoma of bladder. Cystitis.	Nonhemolytic streptococcus.	10.0	Chloromycetin, mandelic acid, penicillin.	Diarrhea, mild.	Improved. Culture - non-hemolytic str.
B. W.	3	F	Chronic cystitis. Normal upper urinary tract.	B. coli communis.	6.0	Mandelic acid, streptomycin, chloromycetin.	None.	Culture - negative. Cured.
J. T.	45	F	Left ureteral calculus. Infected hydronephrosis, grade 2.	B. coli communior	16.5	Streptomycin, penicillin, mandelic acid.	Diarrhea, mild.	Cured. Culture - negative.
S. S.	65	M	Chronic cystitis after prostatectomy.	Str. viridans.	16.5	Sulfonamides, mandelic acid, aureomycin, chloromycetin.	None.	Poor. Unimproved.
J. H. F.	81	M	Urethral stricture. Chronic cystitis. Chronic prostatitis.	B. coli communior	21.0	Sulfonamides, penicillin, mandelic acid, urethral dilatations.	Diarrhea, mild.	Poor. Unimproved.
W. U. S.	90	M	Senility. Paralytic bladder. Benign prostatic hypertrophy, grade 1. Chronic cystitis.	Str. viridans, Staph. aureus.	.25 daily	Sulfonamides, penicillin.	None.	Excellent. Controls pyuria even with catheter. Cultures remain positive.

Table 1.—Results of Terramycin Therapy in 41 Cases of Infection of the Urinary Tract (Continued)

H. E.	67	M	Left hydronephrosis infected. Left ureteral stricture.	<i>B. coli</i> communior.	13.5	Streptomycin, penicillin, sulfonamides, chloromycetin.	Abdominal cramps.	Excellent. Clinically normal with urine micro- scopically negative. Cul- ture - hemolytic str. and <i>Staph. albus</i> .
M. Z.	33	F	Left renal calculi (operative). Left pyelonephritis.	<i>B. coli</i> communis.	16.5	Streptomycin, penicillin, mandelic acid.	None.	Good. Clinically improved. Culture - <i>Ps. aeruginosa</i> .
V. D. A.	52	M	Chronic prostatitis. Chronic cystitis.	<i>B. coli</i> communior, hemolytic str.	23.0	Sulfonamides, penicillin, mandelic acid.	None.	Improved. Culture - <i>B. proteus</i> .
J. I. L.	46	F	Chronic cystitis.	<i>B. coli</i> communior.	9.0	Sulfonamides, streptomycin, penicillin, mandelic acid.	Diarrhea.	Unimproved. Culture - <i>B. coli</i> communior.
A. N. F.	80	M	Chronic prostatitis. Chronic cystitis. Recurrent bladder papillomas.	<i>B. coli</i> communior.	6.0	Chloromycetin.	None.	Improved.
A. S. G.	57	M	Acute urethritis, nonspecific.	Negative.	6.0	Penicillin.	None.	Improved.
D. V.	30	M	Chronic prostatitis.	Gram-negative bacillus.	13.0	Penicillin, sulfonamides, streptomycin, aureomycin.	None.	Improved.
I. M.	30	F	Interstitial cystitis. Chronic cystitis. Normal upper urinary tract.	Hemolytic <i>Staph.</i> <i>aureus</i> .	8.5	Sulfonamides, mandelic acid, penicillin, streptomycin, aureomycin.	None.	Poor. Unchanged.
B. R. C.	56	M	Benign prostatic hypertrophy. Subacute cystitis and prostatitis.	Gram-negative bacillus.	12.0	Penicillin, chloromycetin.	None.	Poor. Unchanged.
W. F. B.	28	F	Acute pyelitis.	Gram-negative bacillus.	4.0	None.	None.	Urine microscopically negative. Excellent.
C. K.	70	M	Chronic prostatitis, 4 oz. residual urine with recurrent infection.	<i>B. proteus</i> .	2.0	Sulfonamides, mandelic acid.	None.	Unimproved.
C. K.	70	M	One stage prostatectomy, suprapubic. (P.O.)	Gram-negative bacilli.	7.0	None.	None.	During convalescence, urine contained 10-15 w.b.c. Good.
M. F.	52	F	Mild cystitis.	Gram-negative bacilli.	2.0	Mandelic acid and sulfonamides.	None.	Unimproved.
H. G.	14	M	Repair of hypospadias. (P.O.)	Not determined.	7.0	None.	None.	Given prophylactically after operation. Urine clear. Fair control of urethral discharge.

Table 1.—Results of Terramycin Therapy in 41 Cases of Infection of the Urinary Tract (Continued)

D. B.	57	M	One stage suprapubic prostatectomy. (P.O.)	Not determined.	12.0	None.	None.	Excellent.
G. N.	84	F	Segmental resection of bladder (trigone) for carcinoma. (P.O.)	Not determined.	11.0	None.	None.	Excellent.
A. V.	28	M	Right ureterolithotomy. (P.O.)	Not determined. (Gram-negative bacilli before operation.)	6.0	None.	None.	Excellent. Fever, 2 degrees for 3 days. Urine uninfected on 17th postoperative day.
L. B.	39	M	Right nephrectomy for calculus pyonephrosis. (P.O.)	Mixed, including Ps. aeruginosa.	10.0	None.	None.	Poor. Profuse Pseudomonas blue drainage. Fever, 1 degree for 8 days. Wound indurated.
W. S.	70	M	Right renal calculus.	Mild gram-negative bacilli.	4.0	None.	None.	Unimproved.
F. J. B.	69	M	Subacute prostatitis.	None found on stained smear.	4.0	None.	None.	Good.
V. D. P.	32	F	Chronic recurrent cystitis.	None found on stain.	3.0	Sulfonamides.	None.	Good. Apparently cured.
F. B.	54	M	Chronic prostatitis. Cystitis after each bladder tumor cystoscopy check-up.	Gram-negative bacilli.	6.0	Sulfonamides.	None.	Cystitis cured. Prostatitis unimproved.
I. L.	66	M	Chronic prostatitis. Cystitis after each bladder tumor cystoscopy check-up.	Not determined.	2.0	Sulfonamides.	None.	Excellent. No cystitis.
I. W.	59	M	Recurrent bladder papilloma fulgurated. Diabetes.	Not determined.	3.0	None.	None.	Good. No reaction.
S. B.	45	M	Left ureterolithotomy. (P.O.)	Gram-negative bacilli.	12.0	None.	None.	Poor. Control no better than other cases with sulfonamides.
A. R.	53	F	Chronic urethritis. Recurrent cystitis.	B. coli communis.	4.0	Sulfonamides, mandelic acid.	Nausea, mild.	Cured.
F. McG.	69	M	Perineal prostatectomy.	Not determined.	3.0	Sulfonamides, mandelic acid, penicillin, dihydrostreptomycin.	None.	Good. Reduced pyuria markedly.
L. B.	52	M	Recurrent perinephritis with right renal calculus, recurrent.	Gram-negative bacilli, staphylococcus.	4.0	None.	None.	Failed. Abscess formed and drained.
L. J.	43	F	Chronic cystitis, after indwelling catheter.	Gram-negative bacilli.	6.0	None.	None.	Cured.

The most distressing reaction occurred in a woman who had a known allergic history. Because of diarrhea and the following symptoms, it was necessary for her to discontinue the drug. Her tongue became sore, and she considered it to be red although it did not appear changed. There was irritation around the anus and in the vagina and the urethra. She had a feeling of burning in the intestinal tract. No other patient had any symptoms of this sort.

Three patients had nausea, 1 of sufficient degree to cause vomiting, which was construed as an indication for discontinuing the drug. The other 2 patients continued the drug, although the nausea persisted, until the total dosage had been taken. Gastrointestinal symptoms subsided within twenty-four hours after the drug was discontinued. No other toxic effects were recognized.

Comments

In choosing the cases to be included in this investigation, we intentionally chose that type of infection which we expected to be resistant to cure. It will be noticed that in a good many of these cases a number of other types of treatment were used without success. Simple urinary infections are susceptible to many drugs, and it did not seem as important to us to show that terramycin would cure simple infections as it would be to show its effect on resistant infections. Consequently, even though there are few cases which are marked cured, nevertheless, under the comments in the column "results," there are a number of excellent and good indications even though some infection still persisted. In many instances, the improvement was better than we would have expected.

The results of this investigation reaffirm the idea that, although the benefit derived from our modern antibiotic and sulfonamide drugs is gratifying, it is still necessary to clear up the underlying or surgical complications which exist in a good many urinary infections. Accurate and complete diagnosis is still necessary if proper care is to be given the patient.

In the dosage administered to the patients in this series, *Bacillus proteus* proved to be resistant to terramycin. Since in many of the cases which were included in this series the disease was of a chronic nature, it appears as if a mixed infection, often including *B. proteus*, exists.

The use of 1 Gm. or less of terramycin daily in the control of infection postoperatively gave generally excellent results. It was not expected that

complete cure would be shown during the immediate postoperative course, but infection was well controlled in all but 1 case. In none of the patients who were receiving terramycin in doses of 2 to 4 capsules daily postoperatively did complications such as thrombophlebitis develop. The absence of toxic effects and the ease of administration indicate that terramycin is useful as a prophylactic postoperatively.

In several cases the results were sufficiently encouraging to warrant special comment.

A debilitated man 90 years of age had an atonic bladder requiring catheterization once daily to remove from 200 to 500 cc. of residual urine even though he voided from time to time. Previous administration of sulfonamide drugs, usually 2 Gm. daily, failed to keep the urine clear, it usually being cloudy grade 1 to grade 2. The administration of .25 Gm. (1 capsule) of terramycin daily kept the urine grossly clear although there were pus cells and a few bacteria microscopically. Since cure in this instance could not be expected, the comfort which the patient received was particularly gratifying.

A man (H. E.) had partial stenosis of the lower end of the left ureter following a segmental resection of the wall of the bladder for an infiltrating carcinoma. Urinary infection persisted chiefly due to grade 2 hydronephrosis on the left side. When terramycin was administered, it was not expected that the infection could be eradicated. As will be seen in table 1, the patient received 13.5 Gm. of terramycin, and the urine became grossly and microscopically clear although the culture still showed hemolytic streptococcus and *Staphylococcus albus*. Perhaps the culture was not accurate, but, at any rate, sixty days after the drug had been discontinued, the urine was still grossly clear and microscopically did not contain white blood cells or bacteria on stained smear.

A woman (J. T.) had a stone 2 cm. by 1 cm. in diameter at the junction of the upper and middle third of the ureter with resulting grade 2 hydronephrosis. Following ureterolithotomy on the left side, the patient was given 16.5 Gm. of terramycin. The urine was grossly clear and microscopically normal; the culture was sterile. Subsequent pyelograms showed that grade 2 hydronephrosis still existed on that side. Terramycin completely eradicated this infection, which would not be expected normally within three weeks of operation.

In no case was chronic prostatitis cured. It may be that the results would have been better if larger doses of the drug had been given. The persistent organism in a number of cases was *B. proteus*. The resistance of this bacillus to terramycin in these cases corresponds to the experience reported in other investigations.

In general, our impression is that terramycin is effective against the common invading organisms in urinary infections and has as wide a range of action as other antibiotics. Serious ill effects were not recognized, and milder ill effects disappeared when the drug was discontinued.

Summary

The pertinent data regarding the effects of terramycin on urinary infection in 41 cases are presented.

The beneficial effect on the group as a whole was satisfactory.

In some cases, terramycin did not eradicate *B. proteus* with the dosage which was administered.

In urinary infection, unless underlying pathologic conditions are properly improved, the effect of terramycin can only be expected to be temporary.

Terramycin is effective against a number of different types of bacteria. In some instances, the dosage can be extremely small.

In this series, ill effects from terramycin were infrequent, were mild, and quickly disappeared when administration of the drug was discontinued.

When the price of the drug permits, administration of larger doses of terramycin may give better results than were obtained in this series.

References

1. The terramycin hydrochloride used in about one half of these cases was furnished by Chas. Pfizer & Co., Inc.
2. Finlay, A. C., and others: Terramycin, a New Antibiotic, *Science* 111:85 (Jan. 27) 1950.
3. King, E. O., and others: Clinical Observations on the Use of Terramycin Hydrochloride, *J.A.M.A.* 143:1-4 (May 6) 1950.
4. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. G.: Terramycin: Some Pharmacologic and Clinical Observations, *Proc. Staff Meet. Mayo Clin.* 25:183-196 (April 12) 1950.

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ABSTRACTS OF MEDICAL ARTICLES

APPENDICES EPIPLOICAE AS A CAUSE OF ACUTE ABDOMINAL PAIN. By Roy E. Campbell, M.D., and Joseph Canipelli, M.D. *J. M. A. Georgia* 38:503-505 (Nov.) 1949.

The authors present 2 cases of infarction of appendices epiploicae and discuss the pertinent literature on the subject. While not commonly observed, torsion with infarction of appendices epiploicae occurs more frequently in their opinion than a review of the literature indicated and should be considered in the differential diagnosis of an acute abdominal emergency. They observed that it may simulate almost any acute abdominal disease, there being only one correct preoperative diagnosis reported in the literature. Listed among the erroneous preoperative diagnosis were acute appendicitis in particular, and also cholelithiasis, torsion of an ovarian cyst, tubo-ovarian lesions, degenerative myoma of the uterus, intestinal obstruction and Meckel's diverticulum.

EMERGENCY TREATMENT OF CHEST WOUNDS. By Morris H. Blau, M.D., F.A.C.S. *South. M. J.* 42:851-855 (Oct.) 1949.

Dr. Blau points out that the proper evaluation and subsequent treatment of thoracic wounds demand that the basic underlying physiologic disturbance be well understood. Usually it is in the delicately balanced cardiorespiratory function and may arise from a combination of circumstances. He discusses the conditions most commonly encountered, which include traumatic wet lung; loss of stability of the chest wall; pneumothorax, both open and tension; hemothorax; and cardiac injuries. In the recognition of these conditions and their changing nature from hour to hour, he emphasized the importance of frequent observations and examinations of the patient as well as bedside roentgenograms of the chest.

ELDERLY PRIMIGRAVID WOMEN. By Lawrence M. Randall, M.D., and John Champneys Taylor, M.D. *Am. J. Obst. & Gynec.* 57:1210-1221 (June) 1949.

In the series of 1,558 cases of elderly primigravid women reported in this article, comparative study is made of data on three groups of primigravid patients from the records of the Mayo Clinic: 250 who were 35 years of age or older, 516 aged 30 through 34 years and 792 less than 30 years of age. Analysis revealed that general bodily conditions related to aging appeared more frequently in elderly primigravidas. Because of reduced efficiency of the genital tract, the more frequently encountered combination of uterine inertia and delay in dilation of the cervix, an increase of frequency of contraction of the bony pelvis and resistance to the soft tissues in the pelvis, operative intervention at a higher level in the pelvis was more often necessary among older patients.

Cesarean section is accorded an increased place in the delivery of infants among elderly primigravidas, an incidence of 12.8 per cent apparently being justified in this group. The principles of prenatal care, now well standardized, should be applied with increased care to these patients, for they experience an increased incidence of toxemia, the authors noted. In their experience the infant bears the major risk when pregnancy occurs in elderly primigravid women.

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FREDERICK J. WAAS, M.D., Chm., 1928...*Jacksonville*
JULIUS C. DAVIS, M.D., 1930...*Quincy*
WILLIAM M. ROWLETT, M.D., 1933...*Tampa*
HOMER L. PEARSON, M.D., 1934...*Miami*
HERBERT L. BRYANS, M.D., 1935...*Pensacola*
ORION O. PEASTER, M.D., 1936...*Tacoma, Wash.*
EDWARD JELKS, M.D., 1937...*Jacksonville*
W. HENRY SPIERS, M.D., 1938...*Orlando*
LEIGH F. ROBINSON, M.D., 1939...*Ft. Lauderdale*
WALTER C. JONES, M.D., 1941...*Miami*
EUGENE G. PEEK, M.D., 1943...*Ocala*
JOHN R. BOLING, M.D., 1944, 1945...*Tampa*
SHALER RICHARDSON, M.D., 1946...*Jacksonville*
WILLIAM C. THOMAS, M.D., 1947...*Gainesville*
JOSEPH S. STEWART, M.D., 1948...*Miami*
WALTER C. PAYNE, M.D., Sec'y, 1949...*Pensacola*

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Ewing Still Stewing

One would think that President Truman's tottering "Health Mate" would have learned by now that there are times when silence is golden. Brought before the lobby investigating committee of the House of Representatives in late July, Mr. Oscar Ewing was not content to be just an indignant witness as Representatives Halleck and Brown questioned him concerning the manner in which his agency has put pressure upon the Congress in behalf of President Truman's socialized medicine program. As the committee began to pry from him details of government lobbying at the taxpayers' expense, the Federal Security Administrator became more voluble. He testified concerning his European tour from Dec. 1, 1949 to Jan. 17, 1950, during which he gave out interviews favoring socialized medicine at almost every European whistle stop. He described his trip as "a survey of health and security programs taken with Presidential approval." He was accompanied on this tour by five assistants, he admitted, and by Mrs. Ewing, whose expenses were not charged to the government, he said. Visits were made to London, Dublin, Edinburgh, Stockholm, Berne, Geneva, Rome, Athens, and several cities in Israel. After his return, Mr. Ewing said, he made 33 speeches throughout the nation, prepared by 65 full time government press agents from material gathered during his European tour.

Mr. Ewing repudiated a suggestion that he might have violated a criminal statute which for-

bids use of federal funds to influence passage or defeat of legislation and he became irate at questions concerning a luncheon for private organization workers at which federal employees served as waiters. The would-be socializer then jumped from the boiling cauldron squarely into the fire when he stated that his government employees whose services were enlisted "were just sitting around" at the time.

Medicine Takes the Public Into Its Confidence

The nation will this month have its ear peculiarly attuned to the cause of American medicine. An unprecedented nationwide advertising campaign is now in progress in some 11,000 daily and weekly newspapers, over some 300 radio stations and in 30 leading national magazines.

The affairs of medicine are no longer just medical affairs. They have, indeed and in truth, become of compelling concern to all the people. Said Dr. Elmer Lee Henderson, new president of the American Medical Association, at the San Francisco meeting: "American medicine has become the blazing focal point in a fundamental struggle which may determine whether America remains free, or whether we are to become a Socialist State, under the yoke of a government bureaucracy, dominated by selfish, cynical men who believe the American people are no longer competent to care for themselves."

It has been said that totalitarianism begins with promises and ends with control. Medicine's program holds out no false promises, offers no effortless solution to the problems that remain in the field of medical care or to those emerging with shiftings of economic, sociologic and political developments. But it does offer the public an opportunity to work with the profession in raising even higher the standards and application of medical science, already the world's best.

By aggressive forthright action, the medical profession has demonstrated again its acceptance of the responsibilities of leadership contingent upon the practice of medicine. It has taken the public into its confidence, and this month sets forth graphically through popular mediums its ideals, its objectives, and the methods believed to be most effective as well as most analogous to the traditional freedom-respecting and evolutionary action which has characterized this nation from its inception and has made it unique in progress and strength. Let every physician familiarize himself with the policies which represent the combined medical thinking at San Francisco so that they may culminate in early unified action furthering the educational campaign now in progress.

Disaster Preparedness

"Our civil defense isn't," said a distinguished commentator recently. Whether it is or isn't is a matter of particular concern to the physician for his is a stellar role in preparedness.

The medical profession, necessarily realistic, today is obliged to face its obligation to the nation in the event of attack with atomic weapons. If the Korean war now in progress proves but a prelude to another global war, the colossal struggle will come knocking at our very doors this time. Civilians, by no choice of their own, will become combatants, and Main Street will be an important military target.

We physicians owe it to our public and to ourselves to give serious consideration to what faces us and how to meet it. We must know now, well in advance, how to marshall our resources to the best advantage. Certainly the fundamental fact emerges that it will be the civilian doctor upon whom the brunt of atomic defense in its medical aspects will fall.

No longer does one need to be reminded that, by their explosive power alone, the new atomic weapons can deal death and destruction on a great-

er scale than the world has ever known, producing a catastrophe of staggering proportions. If we are properly organized, we will know how to deal with the burns, shocks, fractures and internal injuries, as in any disaster. But in addition, there are the complications of radioactivity. Too, many physicians, nurses and other medical personnel as well as equipment may not be available since an atomic bomb is no respecter of persons. The problems facing the civilian doctor mobilized from surrounding territory to work with sanitary engineers and with those charged with the evacuation and feeding of people of all ages from the stricken area are not pleasant to contemplate, but nevertheless thought-provoking and important.

In this issue of The Journal there is published the paper entitled "Medical Planning for Atomic Disaster" which Col. William L. Wilson, Medical Corps, United States Army, presented before the Association at the annual meeting last April. Colonel Wilson is Special Assistant to The Surgeon General and is an authority who has written and lectured extensively on this subject. In this paper, which every member of the Association will undoubtedly wish to study carefully, he points out that the critical test of medical planning rests not only on cooperation and on performance by medical and health services "but, above all, on the success or failure in maximum development and quality of the medical leadership available."

It is high time that we all, as individuals and as members of our county medical societies, give serious thought to what we can do to lay the groundwork for thorough medical preparedness. Once we come to full realization of the magnitude and importance of atomic warfare and the technical requirements for minimizing its effects, all our efforts to inform ourselves of the technical and administrative difficulties involved will bring us nearer to a practical solution.

Changing Age Group Patterns

Shifts in age groups within the population have important effects on the nation's economy and way of life. They concern the physician because they have direct bearing on the demands made upon him professionally.

Census figures for 1950 are to show that children under 10 years of age and old people past 60 account for about 13 million of the total population increase of nearly 20 million. The startling

rise in the number of children under 10 reflects the wave of marriages and high birth rate following the war. The increase of 9 million, from 21 million in 1940 to approximately 30 million in 1950, represents a gain of 41 per cent.

Not only are families with little children in the market for the smaller sizes of clothing and shoes, and for toys of all kinds from tricycles to model airplanes, but they also need the services of doctors and dentists. The existence of 9 million more small children affects the whole economy — more schools, more teachers in the lower grades, more schoolbooks, more suburban homes with more room for children to play, more furniture, more automobiles, more labor-saving devices, more suburban communities with new stores, new theaters, new highways, new playgrounds and playground equipment.

The second largest increase is among old people, a rise of 4 million, or about 30 per cent. Now numbering nearly 18 million, older people also have special needs. The demand arises for expanded pension plans, increased old age benefits, more hospitals. Physicians are called upon to give more attention to geriatrics. Retired persons with assured incomes from pensions and annuities tend to spend their money for books, magazines, radios, television sets and, if possible, small houses of their own.

Increases of 9 per cent in the 20 to 39 age group and 16 per cent in the 40 to 59 age group represent more moderate gains. Only the teen age group shows a decline, down 8 per cent. Owing to the low birth rate that continued all through the depression years of the thirties, boys and girls whose ages range from 10 to 19 years are fewer by 2 million than in 1940.

So it is that both business and government — and likewise medicine — are of necessity being geared to changing age group patterns, especially to increased numbers of the very young and the old.¹

¹Demands Rise with Age Groups: Toys for Young, Pensions for Old, U. S. News & World Report, June 23, 1950, p. 27.

Unexpected Editorial Tribute

Due reference was made before the House of Delegates of the American Medical Association at the San Francisco meeting to the editorial tribute paid Florida physicians and members of allied professions by the United Mine Workers' Journal in commenting on the defeat of Senator Pepper. As mentioned in the report of the Association's delegates appearing elsewhere in this issue, the editor of that publication, who acknowledges forty-four years' experience in covering political campaigns, opined that he had "never witnessed such effective and productive quiet solicitation of votes as demonstrated by Florida's doctors, druggists, dentists, hospital staffs, insurance companies and pharmaceutical representatives, aided and abetted by other professional men." This editor is to be congratulated on his perspicacity.

A.M.A. Clinical Session

Lectures, demonstrations and scientific exhibits at the fourth Clinical Session of the American Medical Association in Cleveland, Dec. 5-8, have been selected primarily for the interest and information of the general practitioner. The scientific session, as well as the scientific and technical exhibits, will be held in the Cleveland Municipal Auditorium. The House of Delegates will meet in the Statler Hotel.

These midyear meetings of the A.M.A., now known as clinical sessions, are in reality a number of smaller clinical sessions on virtually every aspect of medicine. These sessions are scheduled throughout the duration of the meeting with many of them meeting simultaneously. Each clinical session will be limited to an attendance of 100 physicians. These small groups make possible active participation by every doctor in attendance. The discussions will be led by practitioners outstanding in the particular fields.

Among the general subjects scheduled for discussion in the various sessions are obstetrics, featuring difficult cases of interest; pediatrics, including rheumatic fever and psychiatric care; heart disease, with discussions of recent advances in drug therapy, including ACTH; geriatrics, the field of increasing interest; traumatic surgery; latest developments in cancer, diabetes and poliomyelitis; allergic and contact dermatoses and newest developments in syphilology; new developments and refinements of the older technics in anesthesiology,

A. M. A. Clinical Session

Dec. 5-8, 1950

Cleveland, Ohio

and the use of newer drugs in the treatment of gastro-intestinal diseases.

Of special interest to the general practitioner will be scientific exhibits demonstrating fractures, diabetes, rheumatism and arthritis. In addition, exhibits will be presented on cancer, pediatrics, surgical procedures and other subjects.

Again this year color television has been scheduled. A telecast of surgery, clinical treatment and examination will be made from the Western Reserve School of Medicine to the auditorium. This telecast will be sponsored by Smith, Kline & French Laboratories.

A.M.A. Advertising Campaign

The American Medical Association's advertising program has been approved by its Board of Trustees and is scheduled for October.

The main theme of the advertising campaign is to reaffirm and solidify public faith in free enterprise through endorsement of voluntary health insurance and opposition to the trend toward state socialism.

A total of \$1,110,000 has been provided of which \$560,000 has been allocated for a five-column advertising space in every bonafide daily and weekly newspaper in the United States (approximately 11,000). Three hundred thousand dollars has been allocated for 1,200 radio stations covering every state. The remaining \$250,000 is to be spent for space in thirty leading magazines.

Suggested tie-in advertising will be sent to the 11,000 newspapers to aid them in building displays for local advertisers around the national campaign theme "The American Way Is the Voluntary Way." Many organizations such as banks, department stores, Blue Cross, Blue Shield, grocery stores, insurance companies and public utilities will be called on to support medicine's position through advertising.

The AMA advertising schedule is as follows: Weekly newspapers — the week of October 8; daily newspapers — October 11; Sunday newspaper supplements — October 15; national magazines — the week of October 8 for weeklies and the November issue of monthlies which are distributed in October; radio — second and third weeks in October.

Sunday newspaper supplements will include *American Weekly*, *This Week*, *Parade* and 28 independent Sunday magazine sections, representing an estimated total circulation of over 38 million.

Southeastern States Cancer Seminar Jacksonville, Nov. 8-10, 1950

The Fourth Annual Southeastern States Cancer Seminar will be held in the auditorium of the George Washington Hotel in Jacksonville on Wednesday, Thursday and Friday, November 8, 9 and 10. The Duval County Medical Society is in charge of arrangements and will serve as host to the hundreds of physicians expected to attend. This phenomenally successful annual seminar is sponsored by the Florida Division of the American Cancer Society and the Florida State Board of Health with the cooperation of the Florida Medical Association. There is no tuition.

The program has been arranged so as to appeal to the general practitioner as well as to the specialist and covers the entire field of malignant disease. No more distinguished faculty could be assembled to provide graduate instruction in cancer, and all physicians of Florida and the adjoining states are urged to avail themselves of this exceptional opportunity.

The lecturers and their subjects are: Dr. George C. Andrews, Clinical Professor of Dermatology, Columbia University College of Physicians and Surgeons, New York, Tumors of the Skin, and panel discussion on Angioma and Melanoma; Dr. George F. Cahill, Professor of Urology, Columbia University College of Physicians and Surgeons, and Chief of the Urological Service, Presbyterian Hospital, New York, Tumors of the Genitourinary Tract; Dr. Bradley L. Coley, Clinical Professor of Surgery, Cornell University Medical College, and Chief of the Bone and Joint Service, Memorial Hospital, New York, Bone Tumors; Dr. Lloyd F. Craver, Clinical Professor of Medicine, Cornell University Medical College, and Chief of the Medical Service, Memorial Hospital, New York, Malignant Lymphomas and Leukemias; Dr. Harold W. K. Dargeon, Clinical Professor of Pediatrics, Cornell University Medical College, and Chief of the Pediatric Service, Memorial Hospital, New York, Malignant Tumors in Children; Dr. Robert A. Kimbrough, Jr., Professor of Gynecology and Obstetrics, University of Pennsylvania School of Medicine, Philadelphia, Tumors of the Female Genital Tract, and panel discussion on Cancer of the Uterine Cervix.

Dr. Frank H. Lahey, Director of the Lahey Clinic, Boston, Tumors of the Gastrointestinal Tract, and panel discussion on Cancer of the Thyroid Gland; Dr. Hayes E. Martin, Clinical

Professor of Surgery, Cornell University Medical College, and Chief of the Head and Neck Service, Memorial Hospital, New York, Cancer of the Oral Cavity, Lips, Pharynx, Larynx and Nasal Sinuses, and panel discussion on Cancer of the Thyroid Gland; Dr. Richard H. Overholt, Clinical Professor of Surgery, Tufts College Medical School, and Director of the Overholt Clinic for Thoracic Surgery, Brookline, Mass., Tumors of the Chest; Dr. Eugene P. Pendergrass, Professor of Radiology, University of Pennsylvania School of Medicine, Philadelphia, Radiologic Diagnostic Aspects of Malignant Disease, and panel discussions on Cancer of the Breast, Thyroid Gland and Uterine Cervix; Dr. Edgar R. Pund, Professor of Pathology, University of Georgia School of Medicine, Augusta, Ga., Early Diagnosis of and New Tests for Cancer, and panel discussion on Cancer of the Uterine Cervix; Dr. James E. Scarborough, Clinical Professor of Surgery, Emory University School of Medicine, and Director of the Winship Memorial Clinic for Malignant Disease, Emory University Hospital, Atlanta, Ga., panel discussions on Cancer of the Breast and Thyroid Gland and on Angioma and Melanoma; Dr. Shields Warren, Clinical Professor of Pathology, Harvard Medical School, Chief Pathologist to the New England Deaconess Hospital, and Consultant to the United States Navy, Boston, Relation of Atomic Radiation to Malignant Disease, and panel discussions on Cancer of the Breast and Thyroid Gland.

**Graduate Medical Education
Courses Scheduled**

A course in Obstetrics, which will be regional, is the first of a series of courses in graduate medical education to be presented during this fiscal year by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health. Dr. W. J. Deickmann, Professor of Obstetrics and Gynecology, University of Chicago, Chicago Lying-In-Hospital, Chicago, Ill., will be the guest speaker for this three day course beginning Oct. 23, 1950, at the Duval Medical Center, Jacksonville. Clinics and demonstrations will comprise the greater part of the course. Registration is limited to fifteen and must be made in advance.

This is an experimental course for registrants from counties as far south as Volusia and Orange and west to Tallahassee. It is arranged at the

request of the Maternal Welfare Committee of the Florida Medical Association because of its concern over Florida's position as forty-second in the United States with regard to maternal mortality, based on statistics for 1948. If it proves to be of value, it is planned to present it in focal points throughout the state next year.

The schedule of courses for the year ending in July 1951 follows:

Postgraduate Courses		
in Obstetrics	Oct. 23-25	Jacksonville
Special Graduate		
Short Course	Nov. 27-30	Jacksonville
Seminar on Diabetes*	Nov. or Dec.	Lakeland
Ophthalmology and		
Otolaryngology	January	Miami
Cancer — Regional Meetings*		
Hematology	June 22-24	Jacksonville
19th Annual Graduate		
Short Course	June 25-30	Jacksonville

*Dates will be announced later.

To the physicians attending these courses the Department of Medicine is now prepared to give Certificates of Attendance. This additional service is rendered in view of the requirements of some medical organizations, such as the Academy of General Practice, that a certain number of hours be devoted periodically to graduate medical education as a condition of membership. Other organizations are expected to make similar requirements, and it has been suggested that hospitals may begin requiring graduate work of new physicians who wish to retain their position on the visiting staff. It is believed, therefore, that the certificates will be desired by many who attend the courses.

Health Plan Politics

The Truman plan propaganda pamphlet, "Better Medical Care that You Can Afford," is in demand in wholesale quantities in noteworthy quarters. Organizations ordering large lots include Tennessee State Industrial Union Council, Nashville; Brotherhood of Railroad Trainmen and Amalgamated Lithographers of America (CIO), CIO's Political Action Committee and Greater Detroit and Wayne County Industrial Union Council, Michigan.

Medical District Meetings

October 30-November 3, 1950

Dr. Lloyd J. Netto of West Palm Beach, Chairman of Council, the eight councilors and the secretaries of the cooperating county medical societies have completed the programs for the annual Medical District meetings, which will be held this year from October 30 through November 3.

In contrast to the annual convention, the fall meetings are literally taken to the members, being held in a city in each of the four districts. This excellent opportunity enables physicians to reap the benefits of these half day meetings without having to interrupt unduly the routine of their responsibilities.

The officers of the Association will bring pertinent information concerning activities on a state-wide scope that should be of particular interest to every physician. These stimulating messages are designed to keep the members in close contact with the activities of the Association. In addition, a well planned and diversified scientific program is offered for the enlightenment of general and specializing practitioners alike.

Printed programs will be mailed to all members of the Association. Each member is urged to attend the meeting in his district. The meetings will open at 2:30 p.m. on the dates specified below.

Monday, October 30, 1950
Marianna
New Gymnasium

Address of Welcome, James T. Cook, President, Jackson County Medical Society

"Atomic Radiation Delivered by the Bomb," Francis M. Watson, Marianna

Address (by invitation), "Benign and Malignant Lesions of the Vulva," Arthur J. Wallace, Jr., Tampa

Wednesday, November 1, 1950
Ocala
Elks Club

Address of Welcome, Richard C. Cumming, President, Marion County Medical Society

"The Cervical Stump—Necessary Evil?" John P. Michaels, Orlando

Address (by invitation), "The Insulins and Their Use," Sidney Davidson, Lake Worth

Thursday, November 2, 1950
Ft. Myers
Franklin Arms Hotel

Address of Welcome, Walter B. Clement, President, Lee-Charlotte-Collier-Hendry County Medical Society.

"The Management of Hemangiomas," Wesley W. Wilson, Tampa

Address (by invitation), "Surgical Treatment of Benign and Malignant Lesions of Stomach," S. Ward Fleming, West Palm Beach

Friday, November 3, 1950
West Palm Beach
Biltmore Hotel

Address of Welcome, Charles McD. Harris, Jr., President, Palm Beach County Medical Society.

"Management of Massive Hemorrhage From the Upper Gastro-Intestinal Tract," Fred E. Manulis, Palm Beach.

Address (by invitation), "Infertility in General Practice," John W. Nodine, Bradenton

After the scientific assemblies, addresses will be given at each of the four medical district meetings by:

Herbert E. White, President

David R. Murphey, Jr., President-elect

Robert B. McIver, Secretary-Treasurer

Webster Merritt, Assistant Editor of The Journal

Joseph S. Stewart, Chairman, Public Relations Committee

At 5:45 p.m., refreshments will be served by the host societies. Dinner will follow at 6:30 p.m.

At 7:30 p.m., the program will be in charge of Eugene G. Peek, Sr., Chairman, Legislation and Public Policy Committee.

Report of Delegates to A.M.A. Convention San Francisco, June 26-30, 1950

The 1950 meeting of the American Medical Association recently held in San Francisco proved to be one of the most successful in the history of the Association.

During the first three days more than 25,000 persons visited the city as a result of the meeting. More than 10,000 physicians registered during the week of June 26-30, of whom 53 were from the state of Florida. It is interesting to note that the largest previous registration of physicians in A. M. A. history was 15,667 in Atlantic City in 1947. The second largest was 13,221 in Atlantic City in 1949.

The House of Delegates, consisting of 198 members, was the object of considerable new interest on the part of members of the Association, as the attendance at the sessions of the House was greater than ever before. In brief, some of the more important actions of the House were as follows:

1. The adoption of a report on displaced persons.
2. Authorization of a Student Medical Association with the Board of Trustees being given power to initiate such a body.
3. Reports on medical education and medical practice in England were adopted and will shortly be published in *The Journal*.
4. A modified report of the Committee on Hospitals and the Practice of Medicine, which denounced the system whereby hospitals hire salaried physicians for medical care and bill the patient for this care was adopted.
5. Refusal to support the Association of Internes and Medical Students as presently constituted.
6. The House voted support of the World Medical Association, and criticized some hospitals which make membership on specialty boards a requisite for appointment.
7. It voted to continue the association of the American Medical Association with the firm of Whitaker and Baxter for another year, also voted to proceed at once with the expansion of the A. M. A.'s own Department of Public Relations and granted authority to expand some of the special committees of the Council on Medical Service in anticipation of the eventual discontinuance of the National Education Campaign.
8. Subscriptions to *The Journal* were voted to become part of the membership dues, and these dues for 1951 were set at \$25.00.
9. New York City was chosen for the annual convention site in 1953.
10. The House of Delegates elected Dr. John W. Cline of San Francisco as President-elect; Dr. R. B. Robins, of Camden, Ark., as Vice President; Dr. George F. Lull of Chicago, re-elected Secretary; Dr. J. J. Moore of Chicago, re-elected Treasurer; Dr. F. F. Borzell of Philadelphia, re-elected Speaker of the House; Dr. James R. Reuling of Bay-side, N. Y., re-elected Vice Speaker; Dr. Leonard Larson of Bismarck, N. D., and Dr. Thomas P. Murdock of Meriden, Conn., elected to the Board of Trustees.

HOUSE OF DELEGATES: The first meeting of the House of Delegates was called to order by the Speaker, Dr. F. F. Borzell, Monday morning, June 26. Shortly after the invocation was delivered, the Speaker delivered his annual address and appointed the reference committees for this session. The Junior Delegate from Florida, Dr. Louis M. Orr, was appointed on the Hygiene and Public Health Reference Committee.

The annual selection of the recipient of the Distinguished Service Award was the next order of business, and Dr. Evarts A. Graham of St. Louis was elected to receive this award.

President Ernest E. Irons then addressed the House on the continuing fight against Socialized Medicine and Socialism in the American way of life. He sounded an urgent call to arms to continue to enlighten all groups of the American public on the evils of government planning.

President-elect Elmer L. Henderson was then presented to the House by the Speaker.

The report of the Board of Trustees, delivered by its Chairman, Dr. Louis H. Bauer, contained an important announcement on membership dues: "The county society shall determine when the payment of dues is a hardship, but in no case will the American Medical Association dues be remitted unless the county and state dues are also remitted. A person in actual training for not more than five years after his graduation from medical school will be exempted, provided he is also exempted from state and county dues. (2) The dues of a physician who joins his county society after July 1 will be \$12.50; if he joins before July 1, his dues will be \$25 for that year. (3) A physician who transfers from one state or county to another will not be expected to pay the dues a second time; that is, he will not be expected to pay them in the state or county to which he has removed if he paid them in the state or county from which he moved. The Board of Trustees recommends that the House of Delegates take action to set the amount of membership dues at the annual session." This recommendation was acted upon by the House with the result that the dues for 1951 were set at \$25.00.

Relating to the matter of displaced physicians in the occupied zones of Europe and also relating to a number of those who have already entered this country, the Board of Trustees recommended that the American Medical Association recommend to the appropriate departments of the federal government that steps be taken to allow the utilization

of the services of displaced physicians certified by the International Refugee Organization and federal services such as the Indian-Alaskan services under the Department of the Interior, where it is understood there is a great need for more physicians. The Board further recommended that the A. M. A. suggest to the state medical examining boards and to the Federation of State Medical Boards of the United States that they give special study to the present unique situation with respect to displaced physicians with the idea of framing special regulations to meet it.

In summarizing the Report of the Committee on General Practice, the Chairman of the Board of Trustees stated that the American Academy of General Practice, which has already attained a membership of 12,000, is rapidly growing into an important branch of medical practice, but added that the committee thought that an insufficient number of general practitioners are being trained to fill the basic needs of adequate care for the American people, and that there is still an over-emphasis on the training of specialists. The committee further recommended that a higher quality of specialists would be obtained if the candidate for any specialization were taken from the ranks of the general practitioner with several years' experience of practice. A recommendation for integration of general practitioners into hospital staff organizations was also made.

The announcement was made of the expansion of the Washington office, so that at the present time Dr. Joseph S. Lawrence, Director, is assisted by two physicians, one lawyer, one staff writer, and one administrative assistant. The Washington office now occupies an entire floor of the new office building at 1523 L Street, Northwest.

The progress report of the Coordinating Committee was presented by Dr. Elmer L. Henderson, Chairman, who announced that the full power of American medicine's drive to a decision will be turned on early in October with a nationwide advertising campaign. Three principal mediums, newspaper, radio and national magazines, will be utilized. More than 11,000 daily and weekly newspapers will carry medicine's message in dramatic, powerful advertisements designed to give voice to the people's mandate on this issue. Approximately 300 radio stations will carry an intensive spot announcement "campaign," with hundreds of thirty second and one minute announcements being utilized to carry medicine's case to the

radio audience. During the same critical period, when the campaign is being brought to a peak with newspaper and radio presentations, full page A. M. A. advertisements will appear in 30 of the leading national magazines. The Chairman stated that at this time more than 10,000 national, state and local organizations with many millions of members have answered medicine's call during the last year and a half, and have taken positive action against compulsory health insurance or any other form of Socialized Medicine. Voluntary health insurance systems are developing at a phenomenal rate, not only in terms of enrolment, but also in terms of improved coverage. At the present time more than 90,000 individual doctors are actively and progressively participating in medicine's campaign and public relations.

Since the present educational campaign was launched at the start of 1949, more than 77,000,-000 pamphlets, folders and leaflets carrying medicine's message have been distributed to the American people. Reference was made to the editorial in the United Mine Workers' Journal commenting on the defeat of Senator Pepper in Florida. From the editorial, "In 44 years of covering political campaigns in the nation and many states, your editor has never witnessed such effective and productive quiet solicitation of votes as demonstrated by Florida's doctors, druggists, dentists, hospital staffs, insurance companies and pharmaceutical representatives, aided and abetted by other professional men."

The St. Louis Post Dispatch, a paper previously going all out for Socialized Medicine and critical of the A. M. A., admitted in an objective review of the A. M. A.'s National Education Campaign that, "The 140,000 members of the A. M. A. stand high in their own communities. They are well educated and have wide circles of friends, acquaintances, and patients. They take leading parts in community activities. They are in the large cities, towns, and rural communities. Collectively and individually they are now a political force to be reckoned with."

Dr. James R. McVay, Chairman of the Council on Medical Service, gave a detailed report of the activities of the Correlating Committees, which are now assisting the Council on Medical Service in the carrying on of the huge volume of work placed before it. These various Correlating Committees are considering the following problems: Indigent care, medical care of veterans, prepayment hospital and medical service, relations with lay-spon-

sored voluntary health plans, and other subjects. (Dr. Louis M. Orr has been named to serve on the Correlating Committee on Veterans Care.) The report stated that the subject of grievance committees at the state level had received much attention on the part of medical societies. The Council now has information on 12 state medical associations which have committees performing this function. Many local societies have established similar methods and mechanisms for handling grievances. The Council has continued to follow development of emergency call plans and an ever increasing number of local medical societies have set up programs for both night and emergency calls. Many local societies are doing an outstanding job of advertising these services to the public. The Council now has available loan kits and information on organizing, operating and publicizing emergency call plans.

In the supplementary report of the Council on Medical Service the Committee on Voluntary Health Insurance stated that a re-education of the public is necessary to inform it that "medical and hospital care benefits are among the necessities of life to be included with food, clothing, and shelter and that they are not a luxury to be provided by the Federal Government." Reading of the Council's detailed report on page 988, J. A. M. A., July 15, 1950, is recommended.

The Council on Medical Education and Hospitals submitted a report from the Association of Internes and Medical Students with the following conclusion and recommendation:

1. The national association does have the general reputation of being a left wing organization. This reputation would seem to be justified by its history of close and sympathetic affiliation with the International Union of Students, its participation in joint undertakings with American Youth for Democracy and the frank public support that its predecessor the Association of Medical Students has received on at least one occasion from a unit of the Communist Party . . . the Council cannot recommend that the American Medical Association lend its support to the activities of the Association of Internes and Medical Students as presently constituted.

A supplementary report of the Council on Medical Education and Hospitals presented its revision of its "Essentials of Approved Residencies and Fellowships." Those interested in this subject should give careful and detailed reading to the report which begins on page 995, J. A. M. A., July 15, 1950. It is recommended that all hospitals in Florida with approved training programs and those applying for approved programs write the Council for copies of this latest revision.

THE SECOND MEETING OF THE HOUSE OF DELEGATES convened at 1:45 p.m. on Monday, June 26,

with the Speaker presiding. The first order of business was a supplementary report of the Board of Trustees relating to the report of the Committee on Hospitals and the Practice of Medicine. This report contained recommendations by the Board of Trustees on the subject of the purveyal of Medical Service, reviewed the staff hospital-physician relationships, restated the principles of relationship between hospitals, radiologists, anesthetists and pathologists, and made the following suggestions:

1. That the cost of medical services rendered in the hospital should be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.

2. That a physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Contrariwise the physician should not exploit the hospital. It is the sense of this Committee that neither hospital nor physician rendering the service shall exploit the patient or each other.

3. That fees for medical services which are collected by the hospital should be established by joint action of a representative committee of the staff to include the head of the department, and the administrator and the governing body of the hospital.

4. That the basis of financial arrangement between hospital and physician may be salary, commission, fees or such other method as will best meet the local situation, consonant with the Principles of Medical Ethics and with due regard to the needs of the patient, the community, the hospital and the physician.

These four recommendations constitute the main body of the so-called Hess Report. A subsequent supplementary report of the Committee on Hospitals and the Practice of Medicine submitted by the Chairman, Dr. Hess, went on to state that "When a physician believes he has a legitimate complaint against hospital management, he should first attempt to solve the difficulty at staff level and it is incumbent upon the medical staff to assist in arriving at a fair and proper solution. Secondly, if no solution is reached at this level, the physician should appeal to the appropriate committee of his county medical society for advice and assistance. The county medical society committee should develop methods for contacting hospitals, management, and board, as well as local associations representing hospitals, in order that all sides of the controversy may be understood and personality difficulties minimized. The committee offers the services of its offices to assist in the solution to any physician-hospital problem which seems to be unsolvable at the local or state levels. For formal opinion or judgment, however, the portfolio should be presented to the Judicial Council."

During that period of time of the Session of the House devoted to the introduction of resolutions, the resolution on hospital practice of medicine by the Florida Medical Association was presented to the House by Dr. Louis M. Orr of Florida. Many similar resolutions were presented by delegates from other states. A resolution questioning the expenditure for advertising by Whitaker and Baxter from the Delegate from Nevada was rapidly disposed of at the second official meeting of the House, Tuesday afternoon, June 27, by the Reference Committee on Executive Session, with the statement that the committee found nothing in the resolution on expenditure for advertising to warrant an Executive Session. After certain routine business, the House recessed until 5:30 p.m., when it would sit in at the Inaugural Meeting. At this meeting, President Henderson's address was broadcast over a coast to coast network and motion pictures were made of the entire proceedings.

THE THIRD MEETING OF THE HOUSE was held on Wednesday morning, June 28, and dealt principally with the various reports of Reference Committees. The Reference Committee on Reports of Board of Trustees and Secretary rendered its report on the Report of the Committee on Hospitals and the Practice of Medicine as submitted by the Board of Trustees. There was much debate and confusion in the adoption of all the recommendations of this reference committee. The final analysis of their report will be clarified and mailed out at a later date by the Secretary of the American Medical Association and will be presented in a later issue of The Journal of the Florida Medical Association.

Dr. Bauer, Chairman of the Board of Trustees, announced that the contract with Whitaker and Baxter had been extended for an additional year and will expire Dec. 31, 1951. He further announced an expansion of the Department of Public Relations of the American Medical Association, which is to take over at the expiration of the contract with Whitaker and Baxter.

The House reconvened at 2:05 p.m. on Wednesday afternoon, June 28, the Speaker, Dr. Borzell, presiding. This session was occupied entirely with reports of reference committees and was highlighted by an announcement by the Board of Trustees, whose Chairman announced that the House of Delegates that morning had amended the by-laws to provide that dues and membership should include subscription to The Journal of the American

Medical Association, and recommended this change in the by-laws:

Chapter IV, Section 2, (A) (1). A Member Fellow shall pay annual dues not to exceed \$2, as may be determined by the Board of Trustees and announced in The Journal of the American Medical Association. Member Fellows shall be entitled to elect to receive any special scientific journal published by the American Medical Association in lieu of The Journal of the American Medical Association, provided in Chapter II, Section 2, of the By-Laws of the Association.

The Chairman of the Board of Trustees then went on to state that if this amendment to the by-laws is adopted, subscriptions to The Journal of the American Medical Association for nonmembers would be raised to \$15.00. Members will receive it as part of their dues, but nonmembers will pay \$15.00. It was explained that the reduction of \$12.00 to \$2.00 in the fellowship dues is made because the \$12.00 was supposed to cover subscription to The Journal and it would be manifestly unfair to expect members to pay \$25.00 and receive The Journal and then expect fellows to pay an additional \$12.00 for only certain other privileges not associated with receipt of The Journal. This change will materially effect the income to the Association, but it will mean that the fellows will have the privilege of taking any of the scientific journals other than The Journal of the American Medical Association. As they do now, members will be restricted to The Journal itself.

The Chairman of the Board of Trustees then announced that the Clinical Session could not be held in Denver as previously planned and the Board of Trustees decided to have that session in Cleveland, Dec. 5-8, 1950. The reason for the change was labor difficulties in the construction of the new auditorium in Denver.

The Committee on Veterans Affairs presented both a majority and minority report. The minority report was presented by Delegate R. B. Wood of Tennessee, which supported the well known "Shoulders Resolution." Action on this important matter has been deferred until the Interim Session in December 1950.

The Report of the Committee on Amendments to Constitution and By-Laws stated that it had considered the resolution presented by the Board of Trustees relative to approval of fellowship fees, and that inasmuch as this cannot become operative before Jan. 1, 1951, and that the entire question of fellowship should be given further intensive study, it is recommended that this resolution be

referred to the Interim Committee on Members for study at the Clinical Session in Cleveland. The motion for adoption was carried.

The House reconvened on Thursday afternoon, June 29, to receive further Reference Committee reports and resolutions. Dr. E. Vincent Askey of California, Chairman of the Reference Committee on Reports of the Board of Trustees and Secretary moved that the Secretary and General Manager be instructed to have the Report of the Committee which was adopted on the preceding day mimeographed, verified through the Chairman, and mailed to each member of the House of Delegates at the earliest possible time. As previously mentioned, this report will be discussed in a later issue of The Journal of the Florida Medical Association.

Rear Admiral Joel T. Boone then addressed the House, and your particular attention is directed to the careful reading of this remarkable address (page 1161, J. A. M. A., July 29, 1950). Following this address the Speaker called for nominations, which resulted in the unanimous election of John W. Cline of California, President-elect; R. B. Robins, of Arkansas, Vice President; George F. Lull, Secretary; Josiah J. Moore, Treasurer; F. F. Borzell of Pennsylvania re-elected Speaker of the House and James R. Reuling of New York re-elected Vice Speaker. While the tellers were proceeding with the count, the Speaker read a telegram received from the Washington office on the results of the investigation of the Federal Security Agency. Election of new trustees was next in order with the result that Dr. Thomas P. Murdock of Connecticut and Dr. L. W. Larson of North Dakota were elected to the Board of Trustees. This was followed by the election and re-election of members of various councils.

The House adjourned, sine die, on the motion seconded and duly carried at 3:30 p.m. to reconvene at the Clinical Session, December 5, Cleveland, Ohio.

Respectfully submitted,

Louis M. Orr, II*

Homer L. Pearson, Jr.**

* Member of Correlating Committee on Veterans Care.

** Member of Judicial Council.

YOUR BLUE SHIELD

Blue Shield Reminders

(Continued from last month)

Certain types of surgery require that individual consideration be given the claim for benefits before Blue Shield payment can be made. As cases of this nature are reviewed by the Blue Shield Claims Committee, it is necessary that certain medical information be submitted for a fair disposition of the claim. Some of the more frequent procedures requiring such information are listed below with reference to the additional information needed.

Gynecology

As numerous procedures are frequently involved in cases of gynecologic repair work, the physician should always indicate in full detail the surgical services rendered and, if possible, indicate the procedures followed as set forth in the Blue Shield Schedule of Benefits. If the information submitted on the Doctor's Service Report could indicate a question of pregnancy, the physician should state specifically whether the case did or did not involve a complication or accident of pregnancy.

Hernias

In cases of hernia repair, the following information should be submitted:

1. Whether or not the patient was injured on the job.
2. Whether or not the condition was congenital.
3. The duration of the condition as shown by first symptoms.
4. The type of hernia repair and whether or not unilateral or bilateral.

Circumcision

Benefits for circumcision are provided in the amount of \$10.00 when the patient is under fourteen years of age. An allowance of \$25.00 is made when the person is fourteen years of age or more. For that reason, the exact age of the person should be given on the Doctor's Service Report.

Tonsillectomy and/or Adenoidectomy

Surgical Service Code 390 of the Blue Shield Schedule of Benefits provides \$35.00 for tonsillectomy and/or adenoidectomy. A \$35.00 allowance is made under this coding for a tonsillectomy alone and the same provision is made for an adenoidectomy alone. However, when rendered simultaneously, a total allowance of \$35.00 is made for the tonsillectomy and adenoidectomy.

As anesthesia benefits in connection with this service are provided only when the patient is hospitalized as a bed patient, the Doctor's Service Report should indicate whether or not the services were rendered in the hospital or in the doctor's office.

STATE BOARD OF HEALTH

Medical Certification of the Cause of Death

The new death certificate which was placed in use in 1949 puts even greater responsibility upon the medical attendant in the assigning of the cause of death. This was done so that mortality statistics might better reflect expert medical opinion as to the true causes of deaths.

For purposes of consistency in statistical tabulations, it is, therefore, very important that the medical certification be properly executed. Basically, the new certification requires that a sequence of morbid conditions shall be written in reverse chronological order with the last condition arising being written on the first line of Part I. This will result in the underlying cause of death being given last in Part I, and it is to this condition that the death is ordinarily assigned.

A simple illustration of this principle might be a case of scarlet fever followed by acute nephritis with uremia as an end-result causing death. This would be written under Part I as: (a) uremia, due to (b) acute nephritis, due to (c) scarlet fever, and the death would be attributed to scarlet fever. Part II of the medical certification is for other significant conditions which might have made death more likely, but which were not related to the underlying cause. For example, if malnutrition or cancer of the colon were conditions known to be present in this patient, they would have been reported under Part II since neither of these conditions will cause scarlet fever nor result from it.

Another illustration would be syphilitic aortitis which produced narrowing of the coronary ostium with acute myocardial infarction as the direct cause of death — cholelithiasis and pyelitis also present. This would be written in Part I as: (a) acute myocardial infarction, due to (b) narrowing of coronary ostium, due to (c) syphilitic aortitis. In Part II the entry would be pyelitis. Cholelithiasis would not be entered because it probably did not contribute to the course of events as given.

The tenth edition of the "Physicians' Handbook on Death and Birth Registration" which has been sent to all doctors licensed to practice in Florida contains several good illustrations of the new form of certification. Among other things, four case histories are given, and the properly executed medical certifications are shown.

The accuracy and completeness of statistics on causes of death depend in considerable measure on the care exercised by physicians in completing the medical certificate of causes of death. The Florida State Board of Health requests the cooperation of each medical practitioner in the effort to improve the quality of mortality statistics so that they may better reflect medical opinion on causes of death.

Pollen in Florida

In January of this year the Florida State Board of Health began a pollen study covering the whole state. At present twenty pollen traps are in operation from Key West to Pensacola covering both coasts as well as the central portion of the peninsula. In most cases slides are exposed daily by county health department personnel. In one location where there is no local health unit, a public-minded pharmacist is operating the pollen trap. At the end of each month, the exposed slides are shipped to Jacksonville for reading. Monthly reports of pollen counts are sent the respective county health officers.

Ragweed pollen is the object of special attention for the first year of the study. It is essential to know the length of the ragweed season as well as the daily concentration of pollen in air. Already it is clear that the season begins much earlier here than in the North. One curious observation is that ragweed pollen tends to occur in clumps on the slides rather than as discrete grains. This may be a factor in governing pollen travel. Grass and tree pollen are also being counted but no attempt has yet been made to differentiate the various species of grass.

University teaching staffs, private physicians, and many others are assisting in the study. The results of several independent local studies have been made available to the State Board of Health. The information thus obtained will be correlated with the findings of the present study and will be published early next year.

STATE NEWS ITEMS

WARNING! All Florida physicians are cautioned that a young man posing as the son of a Minneapolis physician reputedly has been attempting to victimize doctors by having them cash bad checks. Dr. Henry E. Michelson, Minneapolis, advises that this individual is allegedly operating in Florida, posing as his son and using the name, Robert E. Michelson. He reports that he has definite knowledge that at least one Florida physician has been the victim of this scheme.

Dr. Robert Y. H. Thomas of Jacksonville was recently appointed Duval County's first County Medical Examiner by the Board of County Commissioners.

Dr. Raymond A. Debo of Wilmington, Ohio, who was with the Florida State Board of Health three years ago has returned to the state and has been appointed health officer for the administrative health unit composed of the counties of Sumter and Pasco with headquarters at Dade City.

The Executive Committee of the Florida Heart Association met on August 20 at the Sheraton-Plaza Hotel in Dayton Beach, Dr. Louie Limbaugh, President, presiding. Members of the Board of Directors were invited to attend, and the program needs of the various counties were discussed.

The Twenty-Fifth Annual Meeting of the Congress of Anesthetists will be held at the Roney Plaza Hotel, Miami Beach, Florida, October 30-November 2, 1950. It is sponsored by the International Anesthesia Research Society-International College of Anesthetists. An interesting program has been prepared for this four-day meeting. For additional information communicate with Dr. Maurice P. Cooper, Honorary Vice-President, 716 N. E. 76th Street., Miami 38, Florida.

Dr. Robert F. Moore, formerly of Hinesville, Georgia, is now health officer of the Monroe county health department with headquarters at Key West.

Dr. C. L. Brumback, formerly with the U. S. Atomic Energy Commission, Oak Ridge, Tennessee, has been appointed health officer of the Palm Beach county health department with headquarters at West Palm Beach.

Of the sixty-seven counties in Florida, sixty-four now have full time accredited county health departments. Two other counties have voted to organize county health departments and both will begin operations about the first of October. The one remaining county, Collier, is giving serious consideration to organization of a county health department.

Dr. Robert M. Russell of Mt. Pleasant, Ohio, formerly health officer in Jefferson County has returned to the state and has been appointed health officer in the administrative health unit composed of the counties of Citrus, Hernando and Levy with headquarters at Inverness.

Dr. Frazier J. Payton of Miami recently addressed the Hollywood Rotary Club on the subject of the uses of X-rays.

Dr. James J. Griffiths, Miami, associate director of the Miami Blood Bank, is scheduled to participate in the program of the third annual meeting of the American Association of Blood Banks in Chicago, October 12-14. He will present a paper entitled, "Confirmatory Tests in Determining Titer of Rh Antibody," and, together with Dr. John Elliott, director of the Miami Blood Bank, he will present a paper, "Recent Advances in Cross-Matching of Blood for Transfusion."

The fourth Clinical Session of the A.M.A. will be held in Cleveland, December 5-8, with headquarters at the Statler Hotel. The House of Delegates will meet in the Statler. The scientific session, as well as scientific and technical exhibits will be in the Cleveland Municipal Auditorium. A more detailed description of the Clinical Session may be found in the commentary section of this Journal.

Dr. Cecil M. Hogan of Jacksonville was the guest speaker at a recent meeting of the local Southside Business Men's Club. He chose for his subject the conditions in local nursing homes.

Dr. Lowell S. Selling of Orlando recently appeared as a panel speaker at a conference on the aging held in Washington, D. C. The panel in which Dr. Selling participated dealt with the family life of the aged, living with relatives, and related problems.

Dr. Frederick K. Herpel, chairman of the Committee on Scientific Work, urges any member desiring a place on the scientific program at the annual meeting in Hollywood, April 23-25, to make application by November 1.

Applications, together with a brief synopsis of the paper, should be forwarded to Dr. Herpel at 223 Sunset Road, West Palm Beach.

Any specialty group having an outstanding essayist on its program preceding the Association's annual meeting is requested to make application for this essayist to read a paper of general interest before the scientific assembly.

Physicians who presented papers at the annual meeting in 1950 are not eligible for a place on the 1951 program.

Dr. Herman K. Moore of Key West returned to his practice recently following a trip to Ann Arbor, Michigan, where he had been enrolled in postgraduate study at the University of Michigan Medical School.

The Fifteenth Annual Assembly of the United States Chapter of the International College of Surgeons will be held in Cleveland, Ohio, October 31 to November 3, with headquarters at the Cleveland Hotel.

Surgical clinics will be held in several Cleveland hospitals on Monday, October 30. All scientific sessions will be held at the Cleveland Public Auditorium.

Dr. Frank Lahey, Boston, and Dr. Elmer Henderson, president of the American Medical Association will be guest speakers at the annual banquet on Thursday evening.

For information, write the central office, 1516 Lake Shore Drive, Chicago 10.

Dr. Raymond N. Nelson, formerly health officer in the unit composed of Pasco, Sumter and Citrus counties, has recently resigned and assumed his duties as health officer in the unit composed of the counties of Walton, Okaloosa and Holmes.

Dr. Irving J. Strumpf, formerly of Jacksonville, is now located in the Canal Zone as Chief of the Obstetric and Gynecologic Service of the Gorgas Hospital at Ancon, Canal Zone. Dr. Strumpf advises that he expects to remain there at least for the coming year.

Dr. Lester L. Whiddon of Fort Pierce has returned to his practice following an inspection tour of twenty-one hospitals in England, Scotland, Denmark, Belgium, Switzerland and France. Dr. Whiddon was one of twenty-six doctors participating in this European tour sponsored by the Interstate Postgraduate Medical Association.

The Florida Chapter, American Academy of General Practice will hold its fall meeting at the Orange Court Hotel in Orlando on Oct. 22, 1950. Dr. Robert Greenblatt, professor of Endocrinology at the University of Georgia, will speak on "The Use of Endocrines in General Practice." All doctors are invited to attend.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

All, Frank E., Tallahassee
Batson, Pascal G., Jr., Pensacola
Britt, Otis W., Tallahassee
Haisfield, Harry B., Pensacola
McGuire, John F., Clermont
Oven, Raney A., Tallahassee
Peck, William K., Ft. Lauderdale
Puntereri, Anthony J., Lake City
Sales, Louis M., Jacksonville

WANTED: Young urologist to associate with Board qualified urologist. Write full details first letter to 69-39, P. O. Box 1018, Jacksonville, Fla.

DEATHS**Deaths—Members**

Bay, William F., Bradenton April 14, 1950
 Fellows, James H., Pensacola Aug 4, 1950
 Lancaster, Wilson M., Kissimmee Aug 15, 1950

Deaths — Other Doctors

Coleman, Senator R., DeLand (Col) June 25, 1950
 Sawyer, William B., Miami (Col) July 29, 1950
 Bate, James R., Tallahassee (Col) Aug. 11, 1950
 Eurit, Floyd B., Stuart Aug. 27, 1950
 Meriwether, Thomas, Wewahitchka Sept. 17, 1950

COMPONENT SOCIETY NOTES**Dade**

The regular September meeting of the Dade County Medical Association was held jointly with the Miami Dental Society at the Miami Woman's Club. Drs. Thomas J. Cook and Harold E. Davis presented a paper on "X-Ray Demonstration of Bone Lesions."

Marion

At the regular August meeting of the Marion County Medical Society the guest speaker was Dr. Herbert E. White, St. Augustine, president of the Association. The meeting was held jointly with the Woman's Auxiliary. Dr. White gave an illustrated talk on the Florida Blue Cross and Blue Shield Voluntary Health Insurance programs.

Members present were Drs. William H. Anderson, Jr., Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, John D. Lindner, Carl S. Lytle, William J. McGovern, Robbins Nettles, Eugene G. Peek, Sr., Eugene G. Peek, Jr., Robert E. Thompson, Jack M. Waldrep and Thos. H. Wallis, of Ocala. and Herbert M. Webb, Jr., of Wildwood. Guests present included Drs. L. A. Brendle and J. R. C. Wettstein of Ocala, Gail M. Osterhout, Inverness and Mr. Wm. Harold Parham, Jacksonville.



WANTED: General practitioner for small west Florida community to replace physician being called into service. Estimated gross income \$15,000 annually. Write 69-40, P. O. Box 1018, Jacksonville, Fla.



FOR SALE: By general practitioner going into service, one two-year old 20 amp. X-ray (Profexray) and fluoroscope, \$1200; one six months old Microtherm, \$695. Write 69-41, P. O. Box 1018, Jacksonville, Fla.

Medical Licenses Granted

Dr. Homer L. Pearson, Jr., Secretary of the State Board of Medical Examiners, has reported that of the 227 applicants who took the examination of the Board, held June 25, 26 and 27, 1950 in Jacksonville, 209 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 209 successful applicants follow:

Allen, Ridsen Tyler, Jacksonville (U. of Georgia 1945)
 Alpert, Meyer, Spring Valley, N. Y. (Middlesex 1945)
 Aspis, Samuel Louis, Lake City (Middlesex 1941)
 Bailey, William John, St. Petersburg (St. Louis U. 1941)
 Bartlett, Robert Carl, Wilmette, Ill. (Indiana U. 1945)
 Batson, Pascal Gayle, Jr., Pensacola (Tulane 1944)
 Baum, Samuel, Passaic, N. J. (Tulane 1945)
 Beale, George Lemuel, St. Petersburg (Emory 1941)
 Beatty, Thomas Douglas, Cullman, Ala. (Rush 1937)
 Beckham, Louis Edgar, Jr., Auburn, Ala. (U. of Alabama 1947)
 Berry, James Frederick, Washington, D. C. (Geo. Washington 1947)
 Bloom, John Donald, Miami (Ohio State U. 1950)
 Blumfield, Irvin H., Chicago, Ill. (Jefferson 1949)
 Boivin, Omer Emedee, Fall River, Mass. (Maryland Med. Coll. 1912)
 Bone, Frank Cutchin, Durham, N. C. (Duke 1943)
 Bradford, Edward, Orlando (U. of Maryland 1949)
 Brandt, Ira Kive, New York, N. Y. (Columbia 1945)
 Brannon, Wade Hampton, Birmingham, Ala. (U. of Virginia 1945)
 Bratcher, Leonard Lamar, Jacksonville (Coll. Med. Evangelists 1950)
 Breinin, Goodwin Milton, New York, N. Y. (Emory 1943)
 Breland, Jabe Armistead, Panama City (Louisiana State 1948)
 Brenner, Harry H., Walpole, Mass. (Tufts 1933)
 Broadstreet, Henry Thomas, Jr., Jacksonville (Geo. Washington 1950)
 Broward, John Alden, Coral Gables (Emory 1947)
 Brown, Mark, Nashville, Tenn. (Vanderbilt 1950)
 Brown, Med Scott, Lauderdale, Miss. (Emory 1950)
 Brownlee, Harry Gibson, Sanford (Temple 1950)
 Bush, Gow M. (Col.), Gainesville (Meharry 1949)
 Canakaris, John M., Melbourne (Kansas City U. of P. & S. 1944)
 Carr, Douglas Willits, Miami (U. of Virginia 1950)
 Carter, Donald Dean, Erwin, Tenn. (Duke 1948)
 Carver, Gordon Baxter, Miami (U. of Michigan 1942)
 Certo, Salvatore Italo Amore, Miami (Coll. P. & S., Boston 1945)
 Cheleden, John Joseph, Philadelphia, Pa. (Jefferson 1932)
 Clay, Richard Campbell, Baltimore, Md. (Johns Hopkins 1942)
 Clifford, William Joseph, Coral Gables (Boston U. 1942)
 Clonts, Wilber T., Oakland (Emory 1950)
 Colston, Nathaniel (Col.), Miami (Meharry 1950)
 Corwin, Emanuel Milton, Dover, N. J. (New York U. & Bellevue 1931)
 Coseriu, Vasile Gregory, St. Paul, Minn. (Romania 1946)
 Cotten, Howard Brooks, Birmingham, Ala. (U. of Pennsylvania 1945)
 Courtman, Sol Irving, Miami Beach (Tulane 1950)
 Craig, Robert Leslie, Chicago, Ill. (Temple 1945)
 Cullen, Marvin LeRoy, Dublin, Ga. (U. of Oklahoma 1943)
 Curry, Hiram Benjamin, Jasper (Med. Coll. State of S. C. 1950)
 Davidson, John Keay, III, Lithonia, Ga. (Emory 1945)
 Dean, Henry Leon, Coral Gables (Harvard 1949)
 Delaney, William Morgan, Miami Beach (Georgetown 1940)

- DeVito, James Jerome, St. Augustine (Coll. P. & S., Boston 1948)
- DuPree, Thomas Earl, Decatur, Ga. (Emory 1950)
- Edwards, Thomas Stoneham, Jacksonville (Tulane 1950)
- Epps, George Law, Bainbridge, Ga. (U. of South Carolina 1940)
- Epstein, Edwin, Birmingham, Ala. (Coll. of P. & S., Kansas City 1942)
- Erhard, Elmo Enos, Curwensville, Pa. (U. of Pittsburgh 1934)
- Evarts, Edward Vaughan, Columbia, Tenn. (Harvard 1948)
- Felos, Pete Gus, Tampa (Greece 1941)
- Ferguson, Emmet Fewell, Jr., Desoto, Ga. (U. of Georgia 1950)
- Fernandez, Celestino Garcia, Tampa (U. of Havana 1941)
- Fifer, John Sherwood, Fort Lauderdale (Indiana U. 1946)
- Fleming, James Carlisle, St. Petersburg (U. of Pittsburgh 1941)
- Franklin, Ben Turner, Sr., Orlando (U. of Georgia 1950)
- Free, Jack Rawlins, Doerun, Ga. (Emory 1950)
- Furman, Irvine Keith, Columbia, S. C. (Med. Coll. State of S. C. 1943)
- Gasul, Benjamin M., Chicago, Ill. (Rush 1924)
- Gibbs, Robert Irwin, Jr., Chamblee, Ga. (Emory 1950)
- Gillespie, Elmer Hutchinson, Cedar Key (Harvard 1929)
- Gomberg, Bernard, Chicago, Ill. (U. of Illinois 1941)
- Green, Oscar, Indianapolis, Ind. (U. of Indiana 1947)
- Greene, Joseph Elmo, Aiken, S. C. (U. of Georgia 1949)
- Grove, Helen Irene, Chicago, Ill. (U. of Illinois 1949)
- Grunthal, Leonard Harrison, Jr., Jacksonville (Jefferson 1950)
- Hague, John Ross, Fort Pierce (Hahnemann Med. Coll. of Phila. 1933)
- Hallock, Wilton Johnson, Summit, N. J. (N. Y. Homeo. Med. Coll. Flower Hosp. 1924)
- Hanahan, Ralph Bailey, Jacksonville (Med. Coll. State of S. C. 1934)
- Hardin, Henry Carter, Jr., Miami (U. of Maryland 1946)
- Hardy, James Thomas, Columbia, S. C. (Med. Coll. State of S. C. 1939)
- Harris, Tyndall Peacock, Jacksonville (Duke 1950)
- Harrison, Benjamin Lawrence, Miami (Middlesex 1943)
- Haslup, Allen Lee, DeLand (Geo. Washington 1950)
- Herbert, Alpha Nathan, Miami (U. of Maryland 1925)
- Hester, Lawrence Lamar, Jr., Charleston, S. C. (Med. Coll. State of S. C. 1944)
- Hodnett, James Driver, Atlanta, Ga. (Emory 1950)
- Holmes, Samuel Grant, Galveston, Texas (Harvard 1943)
- Hopkins, George Couper, St. Augustine (Temple 1946)
- Hopkins, George Dearborn, II, St. Petersburg (Long Island Coll. Med. 1946)
- Howard, Herbert Carlton, Coral Gables (Boston U. 1948)
- Humphries, Ivan Clifford, Jr., Atlanta, Ga. (Emory 1950)
- Ivey, John Francis, Jacksonville (Baylor U. 1949)
- Jackson, John Sidney (Col.), Lakeland (Meharry 1947)
- Jackson, Yandle Alvin, Morristown, Tenn. (U. of Tennessee 1932)
- James, Robert Francis, Coral Gables (Marquette 1946)
- Jelstrom, Harry Carl, Ft. Lauderdale (New York Med. Coll. 1946)
- Jensen, Edwin Joseph, Mt. Vernon, N. Y. (Syracuse U. 1943)
- Johnson, Aldis Adelbert, Jr., Coral Gables (U. of Nebraska 1947)
- Johnson, Lawson Crawford, Manchester, Ga. (Med. Coll. of Georgia 1950)
- Keener, Ellis Barlow, St. Petersburg (Emory 1950)
- Kelly, James Raymond, Jacksonville (U. of Pennsylvania 1946)
- King, Albert Gray, Jr., Lakeland (Temple 1947)
- King, Geraldine Anne, Miami (U. of Pennsylvania 1949)
- Kralik, John Joseph, Cleveland, Ohio (U. of Pennsylvania 1949)
- Lawwill, Stewart, Jr., Chattanooga, Tenn. (Vanderbilt 1950)
- Leonard, Lester Irving, Miami Beach (Middlesex 1943)
- Leone, William Abraham, Chicago, Ill. (U. of Illinois 1949)
- Lesselbaum, Harvey Phillips, New York, N. Y. (Ireland 1941)
- Lester, Allen Attaway (Col.), St. Louis, Mo. (Meharry 1950)
- Liddy, Frank J., Arcadia (U. of Toronto 1928)
- Lindeman, Frank Henry, Jr., Leesburg (Tulane 1943)
- Lovelace, Daniel Dudley, Jr., Lake City (Tufts 1934)
- McCallister, Louis Ray, Tallahassee (Emory 1950)
- McNaughton, Robert Avery, Coconut Grove (Harvard 1945)
- McPherson, Albert Ziegler, Little Rock, Ark. (Duke 1945)
- Machle, Williard, Ft. Lauderdale (U. of Cincinnati 1925)
- Manolio, Anthony Peter, West Palm Beach (Italy 1942)
- Maraist, Francis Berchmans, New Haven, Conn. (Johns Hopkins 1948)
- Martin, Wayne Brown, Bellefontaine, Ohio (Northwestern U. 1944)
- Massari, Frank Andrew, Tampa (St. Louis U. 1947)
- Maughon, James Sidney, College Park, Ga. (U. of Georgia 1949)
- Maybarduk, Alexander Peter, New York, N. Y. (New York U. 1939)
- Michaelson, Allen Kommel, Long Island, N. Y. (New York U. 1945)
- Minarik, Harry Joseph, Sanford (Emory 1950)
- Minde, George F., Summit, N. J. (Jefferson 1946)
- Mitchell, George Lee, Jr., Decatur, Ga. (Emory 1950)
- Mixson, William Tunno, Jr., Coral Gables (Temple 1948)
- Moore, Thomas Joseph, St. Petersburg (Duke 1945)
- Mori, Paul Albert, Brownsville, Pa. (Ohio State U. 1948)
- Morrow, Joseph R., Miami Springs (Ft. Worth U. 1910)
- Nabers, Hugh C., Birmingham, Ala. (Long Island Coll. Med. 1944)
- Nathan, Marvin Myer, Bryson City, N. C. (U. of Georgia 1947)
- Nayfield, Ruth Kennedy, Monticello (State U. of Iowa 1941)
- Olivetti, Renzo Giacomo, Bay Pines (Italy 1930)
- Overbey, David Terrell, Jr., Louisville, Ky. (U. of Louisville 1944)
- Owsley, Charlotte Mason, Hartford City, Ind. (Indiana U. 1928)
- Philips, Benjamin Jackson, Jr., Jacksonville (Duke 1945)
- Pizzi, Wilson Bryan, Washington, Pa. (U. of Pittsburgh 1942)
- Portnoff, Clifton Lew, Dearborn, Mich. (New York Med. Coll. 1943)
- Pugh, Charles Marion, Lumpkin, Ga. (U. of Georgia 1949)
- Pullias, George Mitchell, Jr., Miami (Emory 1950)
- Quillian, Jesse O'Berry, Douglas, Ga. (U. of Georgia 1949)
- Read, Frances Elba Myrtle, Jacksonville (McGill U. 1933)
- Reddick, Hilliard Risher, Chipley (Temple 1950)
- Reynolds, James Sylvester, Crescent City (Emory 1950)
- Ritchie, John Andrews, Newton, Conn. (Duke 1943)
- Robinson, Walter Gillette, Alexandria Bay, N. Y. (Syracuse U. 1939)
- Roche, William Patrick, Jr., Chamblee, Ga. (Emory 1947)
- Rogers, Mack Ray, Knoxville, Tenn. (Coll. Med. Evangelists 1949)
- Romaine, Mason, III, Petersburg, Va. (U. of Virginia 1945)
- Rood, Albert David, Jacksonville (Tulane 1950)
- Ruskin, A. W., Jamaica, N. Y. (U. of Bellevue Med. Coll. 1915)
- Russell, Lyle William, Peoria, Ill. (Loyola 1942)
- Sack, Theodore, Boston, Mass. (Harvard 1942)
- Saline, Myron, Whitestone, N. Y. (Chicago Med. Sch. 1947)
- Salter, Paul Pullen, Jr., Birmingham, Ala. (Harvard 1945)
- Sanchez, Adolph Santiago, Atlanta, Ga. (U. of Virginia 1931)
- Schaber, Jack Frederick, Lake City (U. of Cincinnati 1941)
- Schaff, Burnett, Coral Gables (New York U. 1932)
- Schechter, Morris Murray, New Orleans, La. (Tulane 1950)
- Schneider, Coleman Samuel, Port St. Joe (Tulane 1950)
- Schreeder, John M., Chamblee, Ga. (Emory 1950)
- Seiler, Hawley Howard, Orlando (U. of Virginia 1937)
- Sessions, John Turner, Jr., Atlanta, Ga. (Emory 1945)

Sewell, Joseph W., Jr., Tuscaloosa, Ala. (U. of Cincinnati 1946)
 Sharp, Thomas Benjamin, Jr., Atlanta, Ga. (Emory 1950)
 Shorell, Irving Daniel, New York, N. Y. (Georgetown Med. 1923)
 Simpkins, Carl Newton, Jr., Atlanta, Ga. (U. of Georgia 1950)
 Smallwood, Henry Clayton, Swainsboro, Ga. (Med. Coll. of Georgia 1950)
 Smith, Fred Carl, Cedartown, Ga. (Emory 1950)
 Smith, Greene Hampton, Jr., Birmingham, Ala. (U. of Tennessee 1945)
 Smith, William Kenneth, Sedan, Kan. (Vanderbilt 1943)
 Snider, Ross Adkins, Miami (U. of Illinois 1946)
 Sperber, Perry, Providence, R. I. (New York U. 1932)
 Stanford, Freeman DeWitt, Orlando (Emory 1946)
 Stark, Leonard Jerome, Cincinnati, Ohio (U. of Louisville 1939)
 Stevens, Charles Nathaniel (Col.) Quincy (Howard U. 1949)
 Stevenson, Alfred Swope, Orlando (U. of Pittsburgh 1934)
 Stinger, William Raymond, Pittsburgh, Pa. (U. of Pittsburgh 1948)
 Stone, Chauncey M., Jr., Miami (Boston U. 1943)
 Stoneburner, Lawson William, Tampa (Ohio State U. 1943)
 Storey, Wray Donald, Tampa (Duke 1939)
 Strack, Vincent Joseph, Newark, N. J. (Columbia 1934)
 Strickland, Maurice A., Berlin, Ga. (Emory 1948)
 Summers, Paul Lloyd, Orlando (Cornell U. 1948)
 Swift, Walker Ely, Sarasota (Columbia 1919)
 Thomas, Clayton Lay, Tampa (U. of Virginia 1946)
 Tilles, Samuel, Hollywood (Temple 1931)
 Tobin, Walter R., Chicago, Ill. (Loyola 1927)
 Tomson, Nathaniel Charles, St. Petersburg (Vanderbilt 1950)
 Trombly, Frank Willis, Miami (Coll. Phy. & Surg. 1943)
 Trulock, Albert Sutton, Jr., Bay Pines (Emory 1943)
 Turner, Gary Evan, Jacksonville (Med. Coll. State of S. C. 1943)
 Underwood, Edgar Harrison, Jr., MacDill AFB (Tulane 1940)
 VanSant, Claude Victor, Jr., Douglasville, Ga. (Med. Coll. of Georgia 1950)
 Walker, Edwin Mercer, Jr., Pelham, Ga. (Emory 1946)
 Wallace, James Ernest, Jacksonville (Temple 1943)
 Wardlaw, James Langdon, Jr., Madison (New York U. 1941)
 Warnack, Jack Clarence Woodson, Winter Garden (U. of Virginia 1946)
 Watkins, William Thurman, Durham, N. C. (Duke 1945)
 Watson, Robert Manley, Miami (Louisiana State 1948)
 Webster, Charles Matthew, Tampa (Northwestern U. 1942)
 Weiss, Jason, Indianapolis, Ind. (Indiana U. 1941)
 Weiss, Kenneth Sanford, Miami (Chicago Med. Sch. 1947)
 West, Edward McMichael, Atlanta, Ga. (U. of Georgia 1946)
 Wheelihan, Robert York, Elm Grove, Wis. (Northwestern U. 1928)
 Wiley, Charles Richard, Miami (Northwestern U. 1950)
 Wimbish, Ralph Melvin (Col.), St. Petersburg (Meharry 1950)
 Winstead, George Ashby, Atlanta, Ga. (Duke 1941)
 Wright, Samuel S., Lake Worth (Emory 1950)
 Zarzecki, Casimer Aloysius, Charlotte, N. C. (U. of Michigan 1944)
 Zaugg, Frederick Beal, Ann Arbor, Mich. (U. of Colorado 1945)
 Zipser, Lester Louis, Tampa (Ohio State U. 1948)

OBITUARIES

Starling Peters Alderson

Dr. Starling P. Alderson of Coral Gables died unexpectedly of a heart attack at his home on June 29, 1950. He was 62 years of age.

Born in Russellville, Ky., in 1888, Dr. Alderson received the degree of Doctor of Medicine from the University of Illinois College of Medicine in 1909. He returned to his birthplace to practice and at one time served a term as mayor. In 1935 he came to Florida, made his home in Coral Gables and established his office in Miami, where he practiced endocrinology. For a number of years he served on the staff of the Jackson Memorial Hospital as an attending physician.

A Masonic leader, Dr. Alderson was a Past Master of Biscayne Bay Lodge, a former Chairman of the Masters' and Wardens' Association in Miami, and Grand Orator of the Grand Lodge of the State of Florida for three terms, a unique distinction. He was a Shriner and a member of the Scottish and York Rite Bodies; in recognition of his outstanding efforts, the coveted thirty-third degree was bestowed upon him. Active in civic affairs also, he was a member of the Miami Rotary Club, the Century Club and the First Christian Church.

Dr. Alderson was a member of the Dade County Medical Association, the Florida Medical Association, the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Isabel Alderson, a former president of the Dade County Medical Association Auxiliary; two sons, Madison of Coral Gables and Starling P., Jr., of Georgetown, Ky.; two daughters, Sarah and Mrs. David Ferguson, both of Baton Rouge, La.; a stepdaughter, Bebe Daniels of San Francisco; and a sister, Mrs. Charles T. Maxwell, of Sioux City, Iowa.

James Hugh Fellows

Dr. James H. Fellows of Pensacola died at Sacred Heart Hospital in that city on Aug. 4, 1950 following a brief illness. He was 62 years of age and had been in poor health for several years.

A native of Mount Andrews, Ala., Dr. Fellows received his medical degree from the Vanderbilt University School of Medicine and served an internship at Bellevue Hospital in New York City.

(Continued on Page 245)



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Dr. Fellows resided in Pensacola thirty-nine years, serving his community quietly and efficiently as he practiced his profession. He was active in many civic projects related to the medical profession, particularly the new Baptist Hospital and the West Florida Receiving Home. He confined his practice largely to pediatrics. He held membership in the First Baptist Church of Pensacola, was a Mason and was a charter member of the East Pensacola Heights Lions Club.

A member and past president of the Escambia County Medical Society, he had since 1916 been a member of the Florida Medical Association and was also a member of the American Medical Association.

Surviving are the widow, Mrs. Earle Fellows; a brother, Dr. George Fellows of Panama City, and several nieces and nephews.

Ralph Edward Russell

Dr. Ralph E. Russell of Ocala died on July 16, 1950. He was 45 years of age.

Born in Atlanta on Jan. 16, 1905, Dr. Russell was the son of Mrs. Lily Mae Russell and the late Dr. E. A. Russell. He received his medical degree from the Emory University School of Medicine in 1928 and interned at Grady and Wesley Memorial hospitals in Atlanta. In 1932 he came from Fitzgerald, Ga., to Ocala and established practice there, specializing in ophthalmology and otolaryngology. Locally, he was affiliated with the Baptist Church, the Masons, Elks and Kiwanians, and the ATO social fraternity.

A reserve officer in the Army Medical Corps, Dr. Russell was called to active duty on Jan. 7, 1941 and served until Sept. 24, 1945, when he was separated from the service with the rank of captain.

He was a member of the Marion County Medical Society, the Florida Medical Association and the American Medical Association. Also, he was a fellow of the American College of Surgeons and a diplomate of the American Board of Ophthalmology and Otolaryngology.

Surviving are the widow, Mrs. Ollie Edwards Russell, and their young son, Jimmy; a son and a daughter by a previous marriage, Ralph Edward, Jr., a recent graduate of Emory University, and Miss Binky Russell, a student at Wesleyan College; and his mother, Mrs. Lily Mae Russell of Atlanta.



From where I sit *by* Joe Marsh

I Have A "Close Squeak"!

Spent last Saturday morning wandering all over the house. Wherever I went—upstairs or down—I kept hearing a "squeak." Couldn't find out where it was coming from until noon-time when the missus came home from her weekly shopping.

"Listen," I says to her, "hear that squeak?" I started quiet-like across the kitchen and there it went again! "Joe Marsh," she laughs, "that is nothing but your suspender clips rubbing back and forth when you walk!" And darned if it wasn't!

From where I sit, I'd been letting a little thing become a serious problem. Like some little difference of opinion or taste will start off a great big argument. I may prefer a temperate glass of beer with my dinner—while the missus likes tea—but we figure that no two people have exactly the same likes and dislikes. So, why get all "het up" about it?

The moral is, check your suspenders—and check your temper when it comes to little things.

Joe Marsh

simplify the
mother's
problem

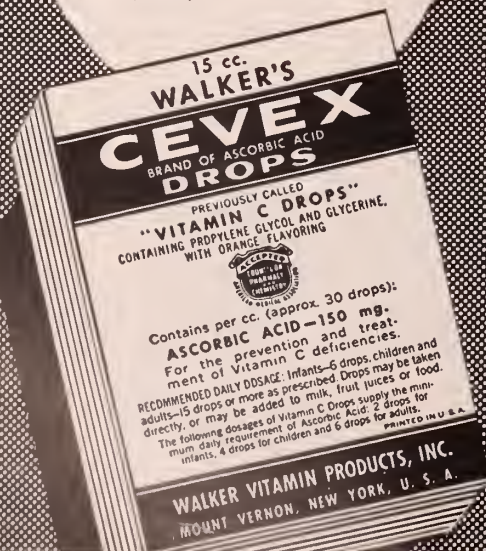
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Edwin Chester Swift

Capt. Edwin C. Swift of Philadelphia, formerly a practicing physician of Jacksonville for many years, died on June 5, 1950 at the United States Naval Hospital in Philadelphia following a brief illness. He was 49 years of age.

A native of Woodbine, Ga., where he was born Oct. 15, 1900, Captain Swift was the son of Addison Knox and Mary Scott Swift. After graduation from the University of Georgia, he attended Emory University School of Medicine, receiving his medical degree there in 1924. After completing a residency at Riverside Hospital in Jacksonville, he located in that city and specialized in the practice of internal medicine. The hospitals with which he was affiliated included St. Vincent's, St. Luke's, Riverside and Brewster hospitals and the Duval Medical Center. During the years of his residence in Jacksonville, he held membership in the Seminole Club, Florida Yacht Club and Civitan Club.

In 1940, Captain Swift entered service at the Naval Air Station in Jacksonville and served for four and a half years, mostly in the Pacific theater, during World War II. He then resumed practice in Jacksonville, but about a year ago returned to active duty with the Navy at the Naval Hospital in Philadelphia, where he was serving when stricken.

Captain Swift was a member of the Duval County Medical Society, Florida Medical Association, American Medical Association and Southern Medical Association, and was a fellow of the American College of Physicians. In 1940, he served as chairman of the Committee on Interrelationships of the Florida Medical Association; in 1941, he was a member of the Committee on Arrangements for the state convention and in 1946 chairman of that committee; in 1947, he was elected first vice president of the Association.

His widow, Mrs. Isabelle Boyd Swift, and a daughter, Miss Isabelle B. Swift, survive him. Also surviving are his father, Dr. A. K. Swift, of Woodbine, Ga.; one sister, Mrs. Helen Daniels of Raleigh, N. C.; and two brothers, A. K. Swift, Jr., and Thomas Swift of Savannah, Ga.

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How? We are like a vast network of pipes laid close to the ground in the heart of every social, civic, and school activity in the country. We are a potential source of unlimited good. We attempt by organizational cohesion to extend this pipe line into arid, uncultivated sectors, irrigating these centers so that interest and cooperation can flourish.

We need interest in the welfare and growth of our country and cooperation in order to achieve the best it can yield. Each non-member is a gap in our pipe line, a void which could be vitally productive of influence. It is of course up to the doctor and his wife whether she remains an aloof entity, or in a spirit of fellowship conforms to the national hook-up of doctors' wives. In soldering at her juncture she provides a further source through which the vast good of this organization can issue and benefit to whatever local group she contributes.

The legislative crisis we weathered by unified action taught us nothing if we fail in total membership in each county now.

We are facing a new crisis. War! Who is better qualified to look after your interests on the home front if you are called to service, than your wife? Can she protect your interests if she is in-

(Continued on Page 248)

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different or uninformed? Can she protest the political action which could jeopardize your future if she is unaware of its existence or ignorant of the proper way to resist it? No! Not any more effectively than a disconnected hose can douse a fire in your own back yard.

Hook up and be prepared! Hook up to the fountain head of information which is like a deep, fresh spring emptying into many rivers.

Mrs. C. Robert DeArmas
President-elect

BOOKS RECEIVED

CEREBRAL PALSY. By John F. Pohl, M.D. Price, \$5.00. Pp. 224. St. Paul: Bruce Publishing Company, 1950.

In this volume the author, who is the orthopedic surgeon at Michael Dowling School for Crippled Children in Minneapolis, sets forth what he believes to be the basic approach to treatment of cerebral palsy, one of the foremost causes of crippling in children. He states that authorities estimate 10,000 new cases occur each year in the United States and that there are 500,000 victims of all ages in this country. Minneapolis statistics indicate that a child with cerebral palsy is born and survives on the average once for each 568 live births.

Although damage to the brain and consequent palsy may occur at any period of life, this study is concerned primarily with children in whom the disorder is either present at birth or occurs in the period immediately surrounding birth. In addition to need for treatment, there are problems in early diagnosis, personal care, social adjustment, education, psychologic management of patient and family, training for work and finally provision of jobs. This book describes the exact and painstaking task of teaching the child how to help himself under the following headings: The Medical Problem; Plan of Treatment—General Principles; Relaxation; Neuromuscular Training; Developmental Patterns; Walking; Occupational Therapy; and Speech.

THE FIRST ANESTHETIC, THE STORY OF CRAWFORD LONG. By Frank Kells Boland, M.D. Price, \$3.00. Pp. 160. Athens, Ga.: University of Georgia Press.

Dr. Boland has taken up the cudgel for Dr. Crawford Long against Boston and Dr. Morton. This volume will attract surgeons, medical men, anesthesiologists, and those interested in the history of medicine in the South. Dr. Boland follows Dr. Long through medical school and into Georgia where the great adventure takes place. Much research has gone into delving for the musty old records proving Long's claim for the honor due him. Charles T. Jackson who suggested ether to Dr. Morton is the villain of the piece and no mercy is shown toward him by Dr. Boland. In the chapter, "Ether Controversy Retold," Dr. Boland attempts to discover how Jackson carried the necessary information from Georgia to Boston. Both the reader and Mr. Jackson appear to get lost along the journey.

Most of the world agrees that the name of Long should precede Dr. Morton. Long, unluckily for the South, was situated in a small town and was too cautious to broadcast his discovery to the medical world until he was sure. For this, the medical profession should respect rather than condemn him.

John T. Stage, M.D.

THE MERCK MANUAL OF DIAGNOSIS AND THERAPY. Ed. 8. Price, \$4.50. Pp. 1,592. Rahway, N. J., Merck & Co., Inc., 1950.

The new Golden Anniversary Eighth Edition of The Merck Manual contains 338 chapters in Part I alone — 82 more than in the preceding edition. More than 100 outstanding clinicians have served as authors and consultants. The compact volume of convenient size and arrangement offers the physician accurate, condensed, readily available medical information which reflects the phenomenal advances in medical research and practice of the last few years. Among the highlights are special mention of antibiotic therapy and treatment with crystalline vitamin B₁₂, together with the latest information at printing time (May 1, 1950) on cortisone and ACTH.

The first printing of 75,000 copies was exhausted by advance orders prior to the publication date of June 1, but but a second printing was made available on July 30. Orders for copies should be addressed to Merck & Co., Inc., Rahway, N. J. The price of the thumb-index edition is \$5.00.



AMUSING QUOTATIONS FOR DOCTORS AND PATIENTS. Edited by Noah D. Fabricant, M.D. Price, \$3.00. Pp. 149. New York: Grune & Stratton, Inc., 1950.

Dr. Fabricant has rendered a pleasing service by gathering in readable, convenient form a selection of amusing quotations dealing with various aspects of the medical scene, its mosaic of interests and ramifications. Included are a variety of proverbs as well as choice utterances of our own time in this collection of sayings that have come down through the ages and from the world over as word play, witty remarks, salty sayings, and those tersely phrased observations of general interest to physicians along a wide front. Writers, orators, philosophers, politicians, thinkers, men of public affairs and, of course, men of medicine are their creators.

Subject headings are arranged alphabetically for ready reference, and a biographic index of the persons quoted briefly identifies who they are and when they lived. So the reader may enjoy the quotations for their own sake, nibbling here perhaps and devouring there as interest dictates, or he may find it convenient to employ them on occasion in the preparation of manuscripts and talks.



PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS. By Paul Haun, M.D. Price, \$4.00. Pp. 80. Architectural Record, 119 West 40th Street, New York 18, N. Y., 1950.

Another "Architectural Record" book is now available from the F. W. Dodge Corporation, attractively printed and bound by The Country Life Press, Garden City, N. Y. This book provides the advice of a specialist systematically presented for study and reference as an aid to architects and hospital administrators confronted with the exacting task of providing the needed psychiatric facilities in local hospitals and coordinating their work with that of the medical and surgical departments.

Drawing on his experience in the design of psychiatric facilities for veterans' hospitals, Dr. Haun, Assistant Professor of Psychiatry at Georgetown University Medical School, describes the history of the hospitalization of a typical patient from entry to discharge. He then analyzes eight separate plans for psychiatric floors, comparing the desirable and undesirable aspects by general areas, and summarizes the factors to be considered in every psychiatric plan.

To Dr. Haun's analysis Charles Butler and Addison Erdman, well known New York hospital architects and authors of the book *Hospital Planning*, have added plans for a six floor general hospital, with the psychiatric floor at the top designed to coordinate with the services of the other floors. The book also contains a bibliography for use in further study.

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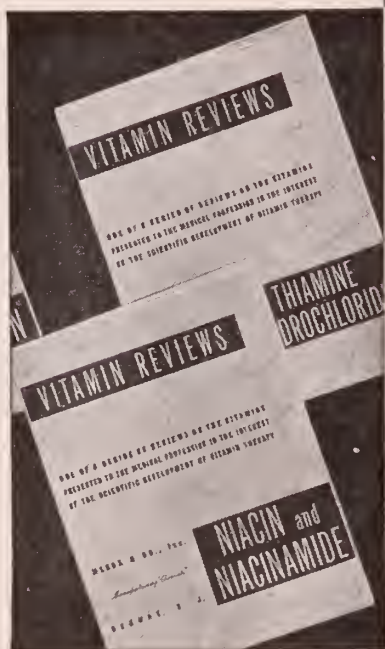
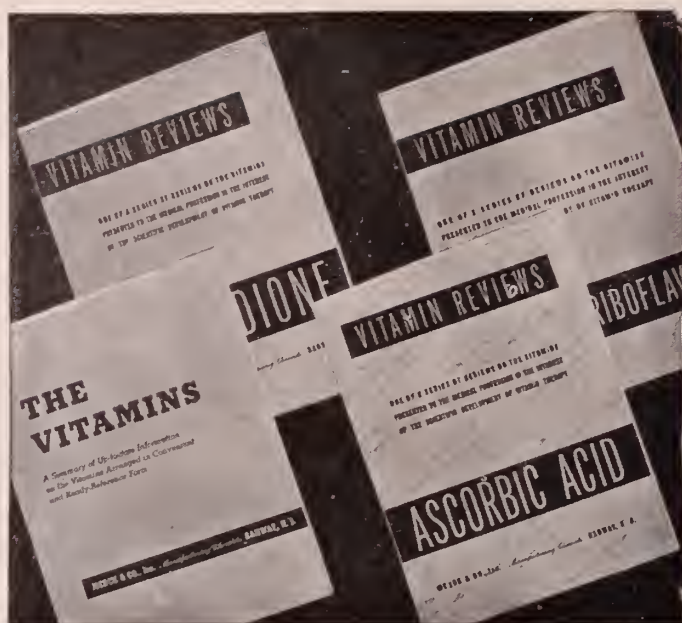
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Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being"

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin'."

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.



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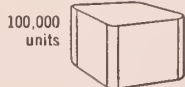
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SURGERY — Intensive Course in Surgical Technic, Two Weeks, starting October 23, November 27. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 9, November 6. Surgical Anatomy & Clinical Surgery, Two Weeks, starting October 23, November 20. Surgery of Colon & Rectum, One Week, starting October 16, November 27. Breast & Thyroid Surgery, One Week, starting October 2. Thoracic Surgery, One Week, starting October 9. Gall-Bladder Surgery, Ten Hours, starting October 23. Fractures and Traumatic Surgery, Two Weeks, starting October 9.

GYNECOLOGY — Intensive Course, Two Weeks, starting October 23. Vaginal Approach to Pelvic Surgery, One Week, starting November 6.

OBSTETRICS — Intensive Course, Two Weeks, starting November 6.

MEDICINE — Intensive General Course, Two Weeks, starting October 2. Gastro-enterology, Two Weeks, starting October 16. Gastroscopy, Two Weeks, starting October 23. Electrocardiography & Heart Disease, Four Weeks, starting October 2.

DERMATOLOGY — Formal Course, Two Weeks, starting October 16. Informal Clinical Course every two weeks.

CYSTOSCOPY — Ten Day Practical Course every two weeks.

PEDIATRICS — Informal Clinical Course every two weeks.

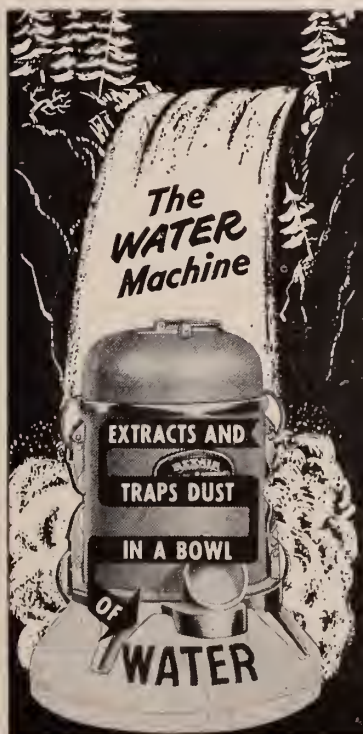
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1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. 209: 33-41 (Jan.) 1945.

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Herbert E. White, St. Augustine.....	Robert B. McIver, Jacksonville.....	Hollywood, Apr. 22-25, 1951
Florida Medical Districts.....	Lloyd J. Netto, W. Palm Beach.....	Council Chairman.....	
A-Northwest.....	Taylor W. Griffin, Quincy.....	Arthur J. Butt, Jr., Pensacola.....	Marianna, Oct. 30, 1950
B-Northeast.....	Cleland D. Cochrane, Daytona Beach.....	Eugene G. Peek, Jr., Ocala.....	Ocala, Nov. 1, 1950
C-Southwest.....	M. Crego Smith, Clearwater.....	Leldon W. Martin, Sebring.....	Ft. Myers, Nov. 2, 1950
D-Southeast.....	S. Marion Salley, Miami.....	Adrian M. Sample, Ft. Pierce.....	West Palm Beach, Nov. 3, '50
Florida Specialty Societies.....			
Allergy Society.....	Clarence Bernstein, Orlando.....	Nelson Zivitz, Miami Beach.....	Hollywood, Apr. 22, '51
Anesthesiologists, Soc. of.....	Ralph S. Sappenfield, Miami.....	Adelbert F. Schirmer, Orlando.....	" "
Chapter, Am. Acad. Gen. Prac.....	T. D. Sandberg, Coral Gables.....	Vincent P. Corso, Miami.....	" "
Chapter, Am. Coll. Chest Phys.....	Arnold S. Anderson, St. Petersburg.....	Alexander Libow, Miami Beach.....	" "
Derm. and Syph., Soc. of.....	Wesley W. Wilson, Tampa.....	Morris Waisman, Tampa.....	" "
Health Officers' Society.....	John M. McDonald, Jacksonville.....	Lorenzo L. Parks, Jacksonville.....	" "
Heart Association.....	Louie Limbaugh, Jacksonville.....	H. Milton Rogers, St. Petersburg.....	" "
Industrial & Railway Surgeons.....	Frank D. Gray, Orlando.....	John H. Mitchell, Jacksonville.....	" "
Neurology & Psychiatry.....	James L. Anderson, Miami.....	William H. McCullagh, Jacksonville.....	" "
Ob. and Gynec. Society.....	Robert T. Spicer, Miami.....	Dorothy D. Brame, Orlando.....	" "
Ophthal. & Otol., Soc. of.....	R. Renfro Duke, Tampa.....	Carl S. McLemore, Orlando.....	" "
Orthopedic Society.....	Chas. L. Farrington, St. Petersburg.....	Herschel G. Cole, Tampa.....	" "
Pathological Society.....	Nelson A. Murray, Jacksonville.....	V. Marklin Johnson, W. Palm Beach.....	" "
Pediatric Association, State.....	Hugh A. Carithers, Jacksonville.....	Charlotte C. Maguire, Orlando.....	" "
Proctologic Society.....	Edward C. Watt, Jacksonville.....	George Williams, Jr., Miami.....	" "
Radiological Society.....	Floyd K. Hurt, Jacksonville.....	Thomas H. Lipscomb, Jacksonville.....	" "
Urological Society.....	Alvin L. Mills, St. Petersburg.....	George H. Putnam, Gainesville.....	" "
Florida—			
Basic Science Exam. Board.....	Paul A. Vestal, Winter Park.....	M. W. Emmel, D.V.M., Gainesville.....	Gainesville, Nov. 11, '50
Blood Banks, Association.....	William C. Thomas, Gainesville.....	James M. McClamroch, Gainesville.....	
Dental Society, State.....	A. J. Fillastre, D.D.S., Lakeland.....	Larry Schulstad, D.D.S., Bradenton.....	Hollywood, Nov. 19-22, '50
Hospital Association.....	Charles C. Hillman, Miami.....	Mother Loretta Mary, Tampa.....	November, 1950
Hospital Service Corporation.....	Mr. W. E. Arnold, Jacksonville.....	Mr. H. A. Schroder, Jacksonville.....	Orlando, Dec. 3, '50
Medical Examining Board.....	William C. Thomas, Gainesville.....	Homer L. Pearson, Jr., Miami.....	Jacksonville, Nov. 26-28, '50
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville.....	Chairman.....	Jacksonville, June 25-30, '51
Medical Service Corporation.....	Leigh F. Robinson, Ft. Lauderdale.....	Herbert E. White, St. Augustine.....	Hollywood, Apr. 22, '51
Nurses Association, State.....	Miss Undine Sams, Miami.....	Miss Helen Shearston, Miami.....	Panama City, October, 1950
Pharmaceutical Association, State.....	Mr. Ed J. Pierce, Jacksonville.....	Mr. R. Q. Richards, Ft. Myers.....	Orlando, May, 1951
Public Health Association.....	Ruth Mettinger, R.N., Jacksonville.....	Mr. Fred B. Ragland, Jacksonville.....	St. Petersburg, Oct. 5-7, '50
Tuberculosis & Health Assn.....	Mr. Dewey Knight, Miami.....	Mrs. Basil E. Kenney, Sr., Port St. Joe.....	Panama City, Mar. 30-31, '51
Woman's Auxiliary.....	Mrs. J. L. Anderson, Coral Gables.....	Mrs. C. R. Morgan, Jr., Miami.....	Hollywood, Apr. 23-25, '51
American Medical Association.....	Elmer L. Henderson, Louisville, Ky.....	Geo. F. Lull, Chicago.....	Atlantic City, June 11-15, '51
A. M. A. Clinical Session.....	Elmer L. Henderson, Louisville, Ky.....	Geo. F. Lull, Chicago.....	Cleveland, Dec. 5-8, '50
Southern Medical Association.....	Hamilton W. McKay, Charlotte, N.C.....	Mr. C. P. Loran, Birmingham.....	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association.....	J. M. Weldon, Mobile.....	Douglas L. Cannon, Montgomery.....	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of.....	Enoch Callaway, La Grange, Ga.....	Edgar D. Shanks, Atlanta.....	Augusta, April 17-20, '51
S. E. Hospital Conference.....	Mr. James E. Crews, Memphis.....	Mr. R. G. Ramsey, Jr., Memphis.....	St. Petersburg, April 4-6, '51
Southeastern Allergy Assn.....	Oscar H. Pruss, Durham, N. C.....	Kath. B. MacInnis, Columbia, S. C.....	St. Petersburg, Jan. 20-21, '51
Southeastern, Am. Urological Assn.....	Edgar Burns, New Orleans, La.....	Russell B. Carson, Ft. Lauderdale.....	Memphis, March 7-10, '51
Southeastern Surgical Congress.....	C. C. Howard, Glasgow, Ky.....	B. T. Beasley, Atlanta.....	Hollywood, April 11-14, '51
Gulf Coast Clinical Society.....	G. O. Segrest, Mobile, Ala.....	E. L. McCafferty, Jr., Mobile, Ala.....	Mobile, Ala., Oct. 5-6, '50

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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	Daniel M. Adams, Jr., M.D. Panama City Hospital Panama City	Jack Corbitt, M.D. Box 961 Panama City		17	16	A-1-52 Arthur J. Butt, Jr., M.D. Pensacola
	Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	69	
	Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
	Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	16	
	Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	18	17	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	49	100%	
	Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	100%	
	Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	3	
	Taylor *Davie-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	216
B	Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 825 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	42	41	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
	Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	245	234	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	27	100%	
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	10	100%	
	St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
	Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	18	100%	
	Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	24	100%	
	Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	137	132	
	Seminole	Charles L. Park, M.D. 212 N. Park Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	13	100%	
	Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	61	56	598
C	Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	153	147	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Millard P. Quillian, M.D. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	20	100%	
	Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	100%	
	Pinellas	Albert R. Frederick, M.D. 116 4th Ave., N.E. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	171	169	
	Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	38	100%	C-6-52 Leldon W. Martin, M.D. Sebring
	DeSoto-Hardee- Highlands- Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	24	
	Lee-Charlotte- Collier-Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	25	24	
	Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	84	80	529
D	Indian River	Melton D. Council, M.D. Box 1096 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	97	96	
	St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	15	100%	
	Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	76	100%	D-8-51 S. Marion Salley, M.D. Miami
	Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	548	496	
	Monroe	Herman K. Moore, M.D. 600 Elizabeth St. Key West	Allen S. Shepard, M.D. 403 Caroline St. Key West	2nd Thursday 8:00 P.M.	11	10	754

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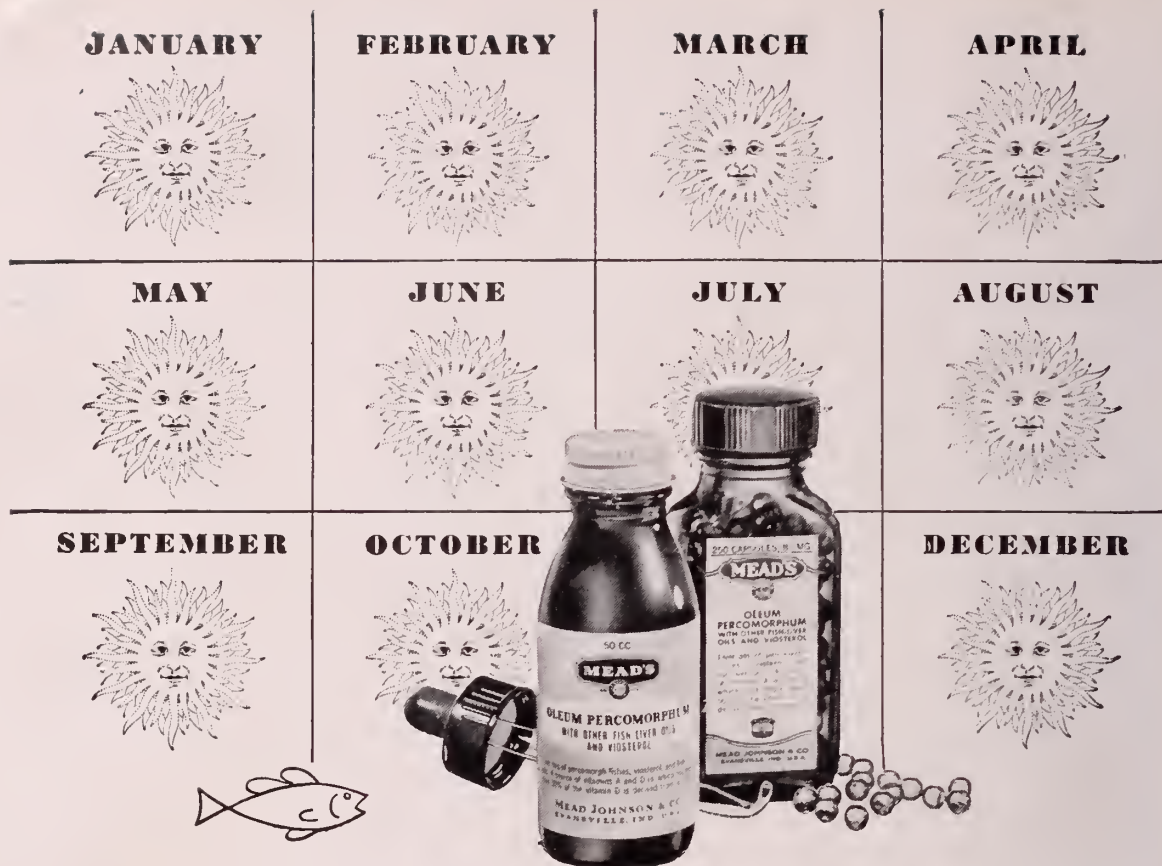
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OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

NOVEMBER, 1950

No. 5

THE N.Y. ACADEMY
OF MEDICINE

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IN THIS ISSUE

Diagnosis in Heart Disease

Elwyn Evans



Parathion Poisoning

John W. Williams



Unhealthy Britain

An Editorial



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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No. 5

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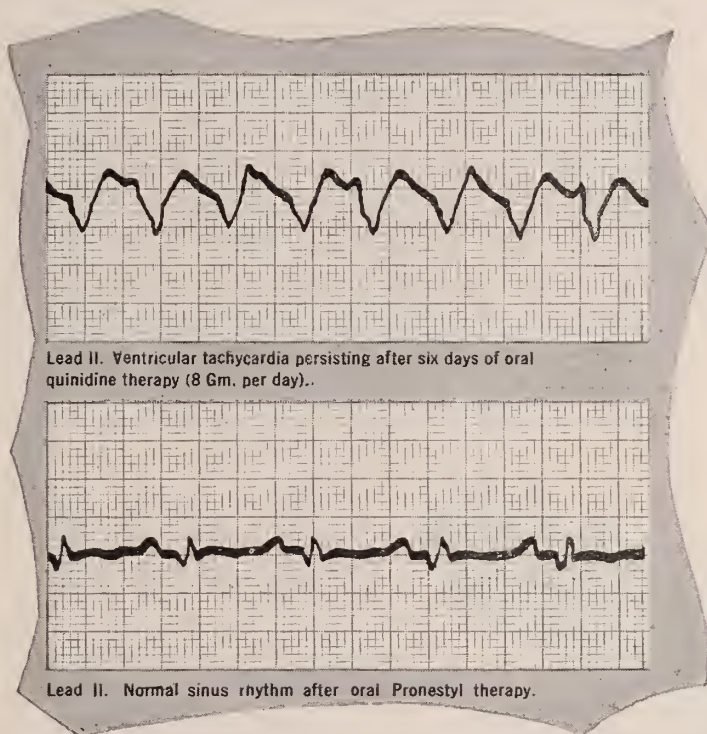
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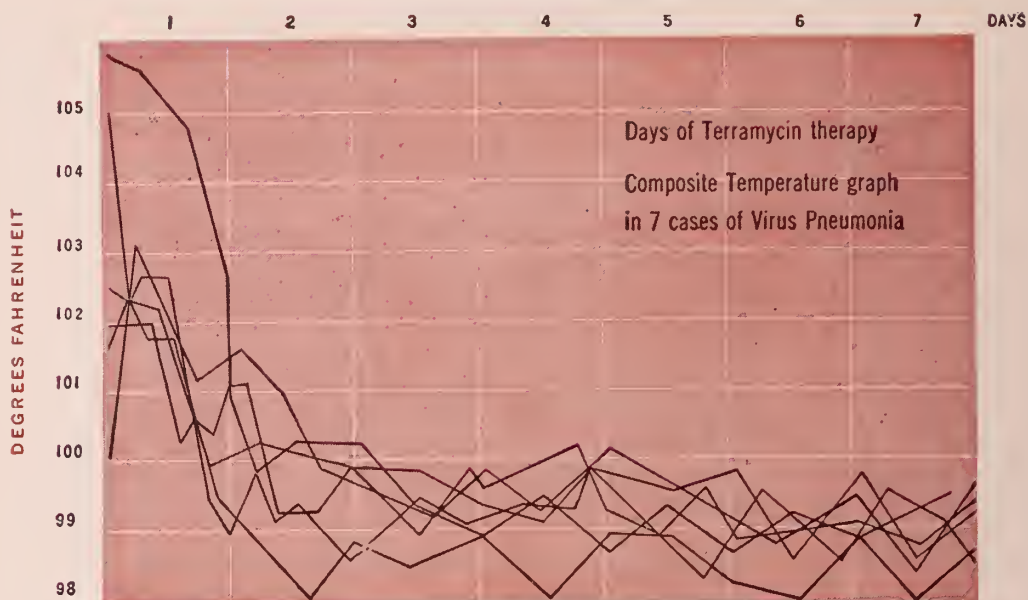
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1. Blake, F. G.; Friou, G. J., and Wagner, R. R.: *Yale J. Biol. and Med.* 22:495 (July) 1950.

2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: *Proc. Staff Meet. Mayo Clin.* 25:183 (Apr. 12) 1950.



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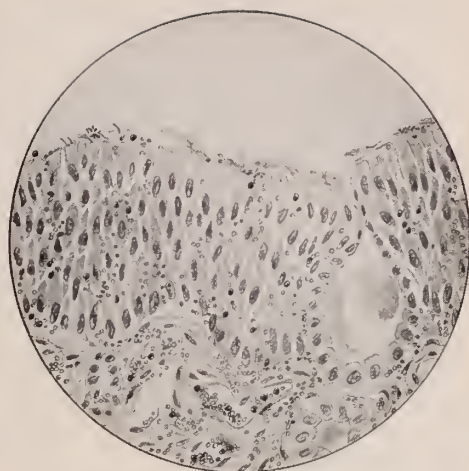
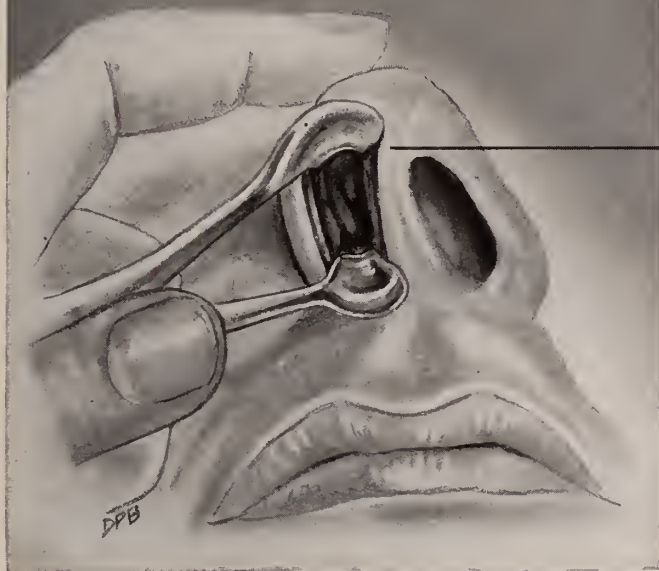
The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., *Ann. Int. Med.* 18:913 (June) 1943.

(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

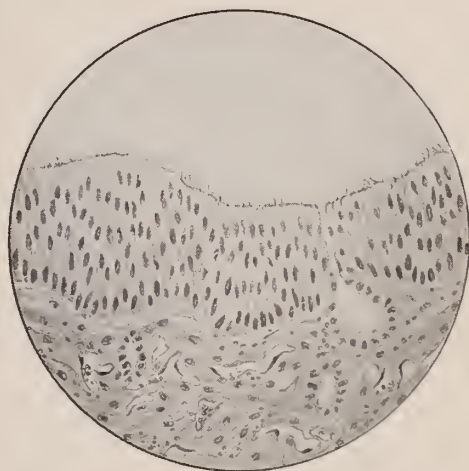
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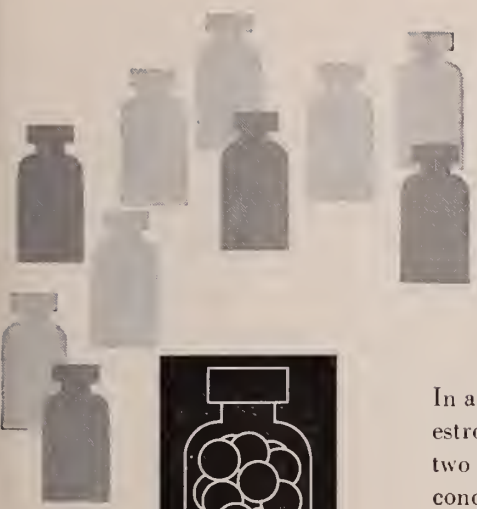
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1. Perloff, W. H.: Am. J. Obst. & Gynec. 58:684, 1949.



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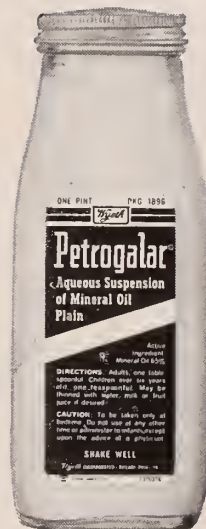
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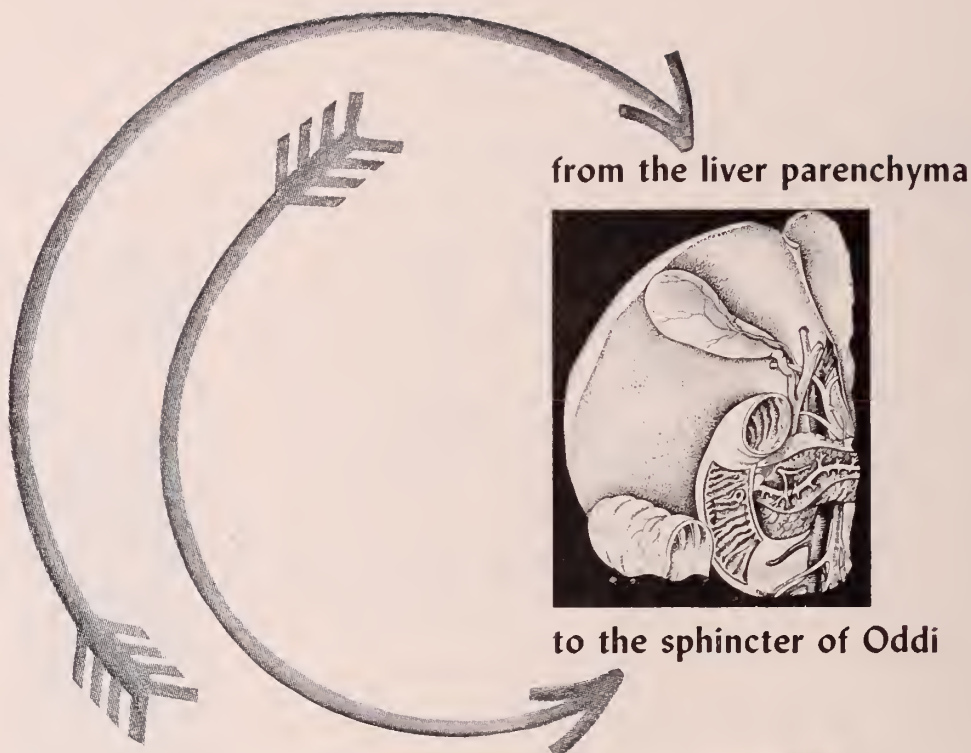
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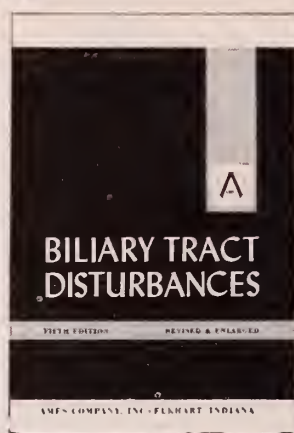


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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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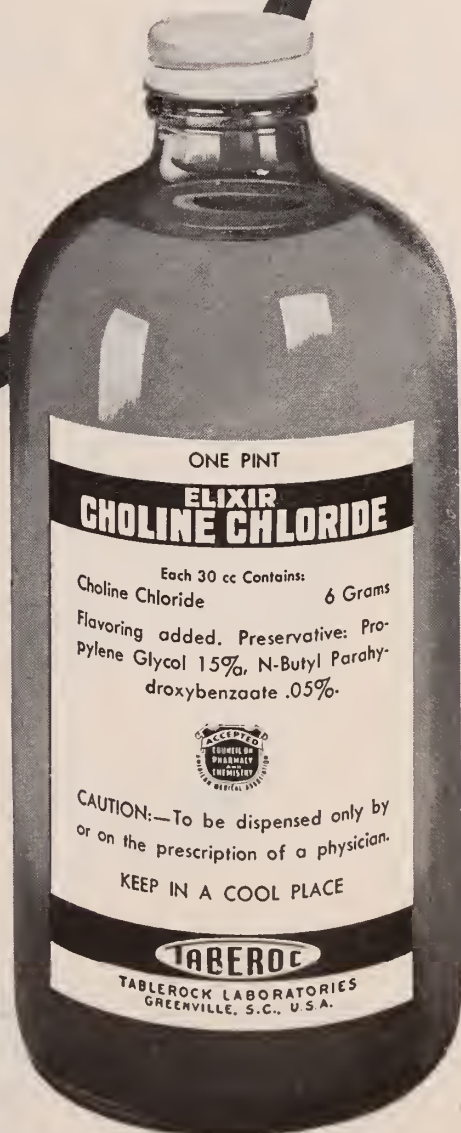
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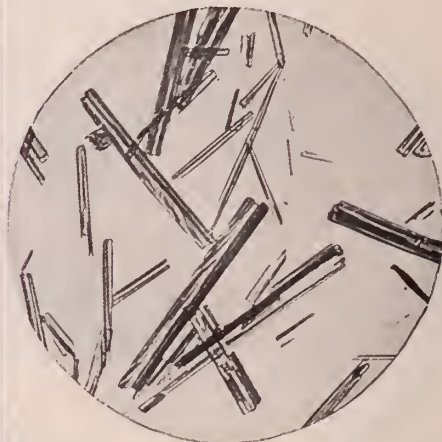
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Diagnosis in Heart Disease

ELWYN EVANS, M.D.

ORLANDO

Evaluation of a patient with possible heart disease should be methodical. Determination of why the patient is seeking medical advice is just as important in the diagnosis of heart disease as it is in diagnosis generally. If this reason is not elicited, the examination may be a failure. The patient usually consults a physician because of the fear of heart disease, symptoms which might be caused by heart disease, or knowledge of some cardiac abnormality such as enlargement or a murmur; however, more and more patients are requesting routine check-ups.

The commonest symptoms or signs which attract the patient's attention are palpitation, tachycardia, pain in the chest or arm, dyspnea, swelling of the lower extremities and cyanosis. To evaluate these properly one should obtain a detailed history, make a general physical examination and perform laboratory tests as indicated. White¹ stated that in his experience the history and physical examination are worth approximately 80 to 85 per cent, the electrocardiogram 10 to 15 per cent, and the roentgen examination, including fluoroscopy, 5 per cent. In an individual case, the electrocardiogram may be worth almost 100 per cent and in another it may be worth little or nothing; the same holds true for the roentgenogram.

Any or all of the symptoms or signs mentioned may or may not be caused by heart disease, and many of them may be associated with functional nervous states. The three most important symptoms of cardiovascular origin are pain in the chest, respiratory distress and palpitation.

Pain in the Chest

Pain in the chest and referred pains are of several kinds.² Precordial aching, usually maximal in the region of the left breast, is the commonest. It lasts for variable periods of time, sometimes radiates down the left arm and is frequently associated with tenderness of the chest, an important clue. It is caused by hypersensitivity of the nervous system from fatigue or other cause. Frequently it occurs in neurocirculatory asthenia or cardiac neurosis. Short, sharp precordial stabs of pain are frequently caused by premature beats in sensitive persons. Both types of pain may come on any time, especially during fatigue, are not related to excitement or exertion and are not relieved by nitroglycerin. When heart disease is present, it is superimposed. The substernal oppression of coronary insufficiency usually comes on with excitement or exertion, particularly after meals, especially in cold weather. It builds up gradually, lasts a few minutes, often radiates to the left arm, occasionally to the right or both arms, the neck, jaw or back, and is immediately relieved by nitroglycerin.

The electrocardiogram frequently shows evidence of coronary disease and when it does not, latent changes can usually be elicited by anoxemia or exercise tests.^{3,4} These tests are not entirely safe; however, Master⁵ when exercising the patient according to his standards based upon the patient's age, sex and weight has never experienced a serious complication. When similar but possibly more severe distress lasts an hour or more, occlusion of one of the coronary arteries is likely. In myocardial infarction, the electrocardiogram usually shows serial changes with Q waves. When infarction occurs, fever, leukocytosis and increased sedimen-

tation rates also appear. The benign form of acute nonspecific pericarditis is a common disease which is usually overlooked and most commonly diagnosed as coronary occlusion. Acute pericarditis may produce pain similar to that of coronary occlusion, except that it frequently follows respiratory infections, is usually aggravated early by body motion, deep breathing or even swallowing,^{6,7,8} and is usually associated early with a pericardial friction rub which is sometimes widespread. When friction rubs occur following myocardial infarction, they do not appear for several days to a week and are likely to be localized. In pericarditis, serial electrocardiograms generally show RS-T and T changes without significant Q waves. Specific diagnosis is important because treatment as well as immediate and ultimate prognosis is quite different in acute benign nonspecific pericarditis from that in coronary occlusion.

Pain caused by a diaphragmatic or hiatus hernia may also simulate coronary disease," but it is not so apt to be associated with excitement or exertion except for stooping, is more likely to be related to meals, is not so consistently relieved by nitroglycerin and is not associated with fever, leukocytosis or Q waves in the electrocardiogram. Pain of an aortic aneurysm is a severe, more or less constant pain in the upper part of the chest, in the neck or in the shoulders. That of a dissecting aneurysm of the aorta is a sudden, excruciating pain located subternally or in the back and radiates from the front to back or vice versa, often down the back to the legs.

Dyspnea

Dyspnea may be due to many causes other than cardiac, especially respiratory diseases such as asthma, emphysema, pulmonary fibrosis, bronchitis and bronchial or trachial obstruction, and functional states such as neurocirculatory asthenia. When pulmonary disease is the cause, the disease usually can be diagnosed, and unless heart disease is superimposed, no cardiac abnormalities can be determined except possibly right ventricular enlargement secondary to pulmonary hypertension. Slight right ventricular hypertrophy is difficult to detect because the right ventricle lies anteriorly, but significant enlargement can be seen in the right anterior oblique position fluoroscopically. Electrocardiographically, there may be right axis deviation or inversion of the T waves in leads II and III and over the right side of the precordium. The R waves become taller over the precordium on

the right side and the S waves larger over the precordium on the left. In fact, prominent R waves may be observed well to the right of the sternum.¹⁰ When there is sufficient pulmonary hypertension to cause right ventricular strain, the second pulmonic sound is increased and is frequently louder than the second aortic sound in the upright position; it may be louder in recumbency in many normal adults.¹¹

The arms to tongue circulation time is not prolonged when dyspnea is secondary to pulmonary disease, but it is when heart disease is the cause. Only occasionally is determination of the circulation time helpful, however, and that is in questionable cases. One method of determining it is to inject 3 cc. of decholin into the antecubital vein with the vein 10 cm. above the level of the bed and the patient at rest in recumbency. The normal ranges from seven to seventeen seconds. Although decholin commonly has been used to differentiate asthmatic from cardiac dyspnea it should not be used in allergic patients because of the rare possibility of a fatal reaction.

Dyspnea secondary to heart disease is caused primarily by exaggerated reflex action on the respiratory center because of engorgement of pulmonary vessels. Such engorgement is caused by mitral valvular disease or left ventricular failure. Pulmonary edema increases the dyspnea, which may be exertional or paroxysmal and nocturnal. If the latter is associated with asthma, it is called cardiac asthma. When mitral valvular disease, stenosis or insufficiency or both, is present, the characteristic murmurs should be audible. The mitral diastolic murmur is best heard in left lateral recumbency after exercise. In mitral stenosis, the first apical sound is usually accentuated, and auricular fibrillation is not uncommon.

When left ventricular failure is the cause of dyspnea, the left ventricle should be enlarged, and if enlargement cannot be detected, another cause should be carefully sought. When the left ventricle is enlarged, the cause usually can be determined. The commonest causes for enlargement are valvular disease, arterial hypertension and coronary disease. Less common causes are congenital defects such as coarctation of the aorta or patent ductus arteriosus, hyperthyroidism, myxedema, beriberi, and other rarer diseases. When the aortic valve is involved, it may be caused by rheumatic fever or syphilis, rarely congenital defects. Failure from syphilitic aortitis with aortic insufficiency usually appears at 40 to 60 years of

age, that from rheumatic disease often earlier, and recurrence of active rheumatic infection is not uncommonly the precipitating factor. There is no associated aortic stenosis in syphilis, an important distinguishing factor.¹²

Murmurs at the apex occasionally are confusing because of relative mitral insufficiency and stenosis and the Austin Flint murmur. The high-pitched, blowing diastolic murmur of aortic insufficiency is best heard in the erect posture during expiration with the patient leaning forward. The serologic reactions may be positive, a history of syphilis may be obtained, or other stigmas of syphilis such as the Argyll Robertson pupil may be present. In rheumatic valvular disease a history of rheumatic fever, growing pains or chorea can often be elicited. When rheumatic aortic insufficiency is present there is a variable degree of aortic stenosis, and in approximately 95 per cent of the cases the mitral valve is also involved. When hypertension is the cause of left ventricular enlargement and failure, the diagnosis is generally easy. In those cases in which the arterial pressure is not significantly elevated, a history of hypertension and changes in the eyegrounds showing arteriovenous nicking, exudates or hemorrhages are helpful.

Regardless of the cause of left ventricular enlargement, the electrocardiogram is likely to show changes suggestive of such enlargement. Left axis deviation may or may not be present. RS-T segments are depressed in lead I and over the precordium on the left side, and the T waves are often diphasic (minus-plus type) in these leads.^{13,14} Other findings are increased amplitude of the R waves in lead I and especially leads over the left side of the precordium; they are decreased over the right side of this area where the S waves are enlarged.¹⁵ When coronary disease is at fault, a history of angina pectoris or coronary occlusion is frequent, and the electrocardiogram usually shows evidence of coronary insufficiency or myocardial infarction.

Regardless of the cause of left ventricular failure, tachycardia of some sort not uncommonly precipitates the failure. Hypermetabolism and anemia per se rarely cause dyspnea, but they aggravate any tendency that may be present.

Palpitation

Palpitation is a common but less important symptom than pain or dyspnea. It is an unpleasant sensation of the heart beat whether it is slow or fast, regular or irregular, and usually occurs in nervously sensitive persons.

Edema

Edema and cyanosis are the two most important signs. Edema of the extremities is of the dependent type, maximal in the shins and ankles with the patient upright and over the sacrum with the patient recumbent. In an ambulatory patient, unilateral edema is caused by some local disturbance in circulation. Even bilateral edema is more likely to be on a noncardiac than on a cardiac basis, especially a disturbed venous circulation such as venous obstruction or dilatation. Digitalis has no effect on dyspnea or edema that is not of cardiac origin. When edema is secondary to left ventricular or pulmonary disease and subsequent right ventricular failure, the disease should be diagnosable. If none of these causes is evident and the venous pressure is elevated, pericardial or tricuspid disease should be looked for. In pericardial effusion and chronic constrictive pericarditis, the heart sounds tend to be weak, the pulsations feeble and the pulse pressure narrow with a low systolic pressure, and evidence of calcium deposits may be seen on the roentgenograms, especially the lateral view. In effusion, the cardiac silhouette is increased, and fluid may be obtained by pericardiocentesis; in constrictive pericarditis, the cardiac silhouette tends to be small. In both, murmurs are slight or absent.

Tricuspid disease is difficult to diagnose. It has the same etiology as mitral disease and invariably is associated with it. The murmurs are similar to those of mitral disease and are heard nearer the midline, but the invariable involvement of both valves complicates the diagnosis. A striking feature of patients with tricuspid disease is that enlargement of the liver may be present for years without serious discomfort or dyspnea, even in the presence of ascites and possibly hydrothorax. The right side of the heart is invariably enlarged. With tricuspid insufficiency one can observe pulsations of the liver and the veins of the forehead or forearms. In both tricuspid disease and constrictive pericarditis, the venous pressure is elevated. The venous pressure normally varies from 6 to 10 cm. of water. A simple but satisfactory clinical method of measuring it is to determine the distance the veins of the neck are distended above the lower edge of the right third costochondral cartilage. They should not be distended above the clavicle with the patient erect.

Cyanosis

There are numerous causes for cyanosis—cardiac, respiratory and others. Unless it is pro-

nounced and permanent, it is often caused by local circulatory disturbances. When of great degree and produced by cardiac disease, cyanosis may be caused by left and/or right ventricular failure or by one of several congenital lesions in which venous blood is shunted into the arterial circulation, for instance, a single ventricle, dextro-position of the aorta with overriding of both ventricles, or transposition of the great vessels. Cyanosis may occur terminally in patent ductus arteriosus and interauricular or interventricular septal defects.

Summary

This material is presented to give a general idea of the problems and methods of diagnosis in heart disease without a thought of presenting complete details or anything new of significance. Clinical aspects are emphasized, but several laboratory procedures are mentioned because they are frequently useful and occasionally necessary for diagnosis.

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Discussion

DR. E. STERLING NICHOL, Miami: Dr. Evans has summarized effectively the basic diagnostic signs in heart disease. It is impossible to overemphasize the value of a detailed history in the diagnosis of angina pectoris, which is a clinical syndrome and not a pathologic entity; so the diagnosis must be based almost entirely on the history. Analysis of pain in the chest must be detailed, and the relationship to effort, ingestion of food, aggravation, or excitement, and the rapidity of relief from nitroglycerin, amyl nitrite or whisky, all have a bearing on the diagnosis of angina pectoris. A common error is to dismiss lack of

relief with "nitro" as evidence against angina pectoris without discovering that the dosage was too small to produce vasodilatation of the cerebral veins (headache). Another error is to assume because belching of gas affords relief that one is dealing with "indigestion" rather than angina pectoris. Be slow to diagnose as angina pectoris a discomfort which cannot be brought on by walking fast or up a slight grade, particularly after a meal or in cold weather. And do not be misled because the pulse is not accelerated or remains good during the attack. Many physicians and all nurses are fooled by this paradoxical phenomenon, but if they had taken the blood pressure during the attack it would likely have been elevated.

Occasionally when the electrocardiogram gives negative evidence even after an exercise tolerance test, a tracing obtained during an anginal episode will reveal definite evidence of coronary insufficiency.

Breathlessness on slight exertion is the earliest and most important symptom of left ventricular failure. Misinterpretation of the symptom "dyspnea" is a common error. Do not accept a patient's word for dyspnea, but elicit a description of this symptom as often a functional sighing type of inspiration not due to congestive failure or anginal equivalent is described by patients (particularly in this climate) even in the presence of organic heart disease. Dyspnea without left ventricular hypertrophy is usually of pulmonary origin. Dyspnea in the absence of accentuated P2 is rarely of cardiac origin. Insomnia is a frequent sign of left ventricular failure in old people and may precede nocturnal dyspnea.

I cannot agree with the author that physiologic measurements of the arm to tongue circulation time and venous pressure are seldom helpful in diagnosis. A week seldom passes that I have not been saved from error, or had my attention drawn to a discrepancy in bedside diagnosis, by the simple determination of a calcium or decholin arm to tongue time. For example, the presence of latent hyperthyroidism in patients with congestive heart failure is suggested by a normal arm to tongue time instead.

Edema of the ankles in the absence of increase in venous pressure is sure to be noncardiac in origin. If the veins of the neck cannot be filled above the normal level in the semierect position, particularly with pressure over the liver, do not attribute edema of the ankles to heart disease. Hepatomegaly of noncardiac origin can best be differentiated at the bedside sometimes by venous pressure measurements.

DR. EVANS, concluding: Speaking of nitroglycerin, I think if the patient does not get relief after taking nitroglycerin two or three times in ten or fifteen minutes, he is not going to get relief, and more harm may be done by taking more nitroglycerin because of decreased blood pressure. I will agree that some patients are more susceptible or less susceptible than others and that it is well to push nitroglycerin therapy to the point of getting fullness or pain in the head if necessary to get relief from the pain in the chest.

Speaking of walking in connection with angina, I have a patient who can walk at a certain gait without difficulty, but if he knows that he must be somewhere at a certain time, and walks at that same pace, he will have angina. So, the emotional factor is especially important, and it is one of our difficulties because we cannot evaluate the emotional problem.

With reference to the arm to tongue circulation time, I will mention this point — if the patient has any history of allergy, one should be careful about giving intravenous decholin.

Roentgen Examination in Acute Surgical Conditions Within the Abdomen

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AND

BERT H. MALONE, M.D.

JACKSONVILLE

The roentgen examination of the abdomen in acute surgical conditions may be of inestimable value in certain cases and in some will lead to a diagnosis. Although in the majority of cases the disease is usually diagnosed by the clinical findings and laboratory studies, there are other cases in which the diagnosis is not as apparent, and it is in such cases that the roentgen examination proves to be of greatest benefit. It is believed that a review of the changes produced by disease within the abdomen as manifested on the roentgenogram is timely and will be beneficial, for if one knows what changes to look for or expect, they can be more readily seen and evaluated. A roentgen examination is a factual study, and a knowledge of the changes produced by disease within the abdomen is necessary for correct interpretation because the significant findings are often small and easily overlooked. The examination requires no preparation of the patient and, if necessary, can be performed at the bedside with a portable unit.

Normally there is a little gas in the colon, but there is usually none in the small bowel. Frequently the stomach and duodenum can be seen outlined by gas; the liver and spleen as well as the kidneys are more or less readily apparent. The psoas muscles and the quadratus lumborum are also visible.

Roentgen Evidence of Disease

The demonstration of free gas in the peritoneal cavity is an examination which we are frequently called upon to perform. It has been our experience that gas can be most easily shown by making a single roentgenogram of the chest with the patient upright, when the gas will be seen under either leaf of the diaphragm. This examination has an advantage in that the lungs can be studied at the same time. If the patient is too sick to sit, he can be turned on his left side and a roentgenogram made in the left lateral decubitus position, when

the gas becomes pocketed between the diaphragm and the liver. Free gas nearly always means a ruptured peptic ulcer. In this connection it is well to remember that following abdominal operations free gas can be demonstrated in the peritoneal cavity for as long as two weeks following surgery and does not necessarily mean a perforation or a leak.

In patients with ureteral colic the intestinal tract is frequently dilated and filled with gas. This fact is sometimes overlooked, and often we are called upon to examine these patients because their referring physicians believe that they are suffering from mechanical obstruction of the small bowel. Fortunately 90 to 95 per cent of stones in the urinary tract can be seen on the plain films. If the stone should be nonopaque, an intravenous pyelogram can be made without greatly disturbing the patient, and this will then demonstrate the block.

Mechanical obstruction of the small bowel can produce changes which are diagnostic, and it is important this condition be recognized early for it can prove fatal. If the pathologic changes occurring in the bowel are recalled, the correct interpretation can usually be made. The characteristic picture shows dilated loops of small bowel lying transversely in the abdomen in the so-called step-ladder appearance. The distended small bowel can be distinguished from the colon by the presence of valvulae conniventes, which are prominent and persist. Distal to the obstruction the bowel is not distended, and if the colon does contain gas, it is not dilated. The obstructed loops are large and dark and greater in the transverse diameter than in the vertical, and there is pronounced contrast between this bowel and the background of the abdomen. The bowel is dynamic, and repeated examinations show that the loops have different arrangements. These changes serve to distinguish

the condition from paralytic ileus, in which the loops are unequally dilated, and at times are segmental in appearance; and in addition, there is in proportion the same degree of dilatation of the colon as of the small bowel. In the paralytic bowel the loops are shallow and not dark. In mechanical obstruction distention of the small bowel occurs early in the course of the disease, sometimes within six hours after onset, so that a roentgen examination can and should be made early. Not infrequently, the examination will have to be done again before the true nature of the condition can be determined. Although adhesions are the commonest cause of mechanical obstruction, it is seldom that the etiology can be determined from the plain film. One exception is gallstone ileus, when the gallstones can be seen and the presence of gas in the bile ducts indicates a fistula. In a few cases, there can be obstruction of the small bowel without roentgen evidence of its presence.

Obstruction of the colon in the adult is usually due to a carcinoma or volvulus. In the former, the colon is uniformly dilated down to the obstruction and is accompanied by distention of the small bowel if the ileocecal valve is incompetent. If the valve allows the small bowel to become distended, the picture can simulate the findings of obstruction of the small bowel.

In volvulus of the colon the distended loop can be seen arising up out of the pelvis on the right side and in the middle of the abdomen. The roentgen findings in this condition are characteristic and must be recognized as it requires an entirely different surgical treatment than an obstructed colon from a carcinoma. The commonest cause of colonic obstruction in children is intussusception, either ileocolic or colocolic, and it sometimes can be diagnosed from the plain film; however, to prove the suspected lesion, a barium enema should be given.

Generalized peritonitis will cause distention of the small bowel, with loops which are fixed in position and usually of the paralytic type. The space between the loops is increased, due to the exudate, and there is obliteration of the properitoneal fat line. Localized abscesses will sometimes reveal themselves by the presence of gas which lies outside the bowel and has a configuration which does not correspond to the size or shape of the bowel. This can be especially helpful in infections about the appendix. Gas formation in an abscess may be very small in amount and must be looked for

zealously, if it is to be identified. It is usually arranged in small vesicles or clusters. Gas formation in retroperitoneal abscesses usually lies in the fascial planes and outlines the psoas muscles and kidneys. Fixation of the kidneys is an invaluable sign in perinephritic abscess. It has been shown by Weens that in his series of cases the gas-producing organism was the *Endamoeba coli* and the anaerobic streptococci.

Summary

Roentgen manifestations of the changes produced within the abdomen in acute surgical conditions are described. The value of roentgen examination in demonstrating free gas in the peritoneal cavity and in the diagnosis of ureteral colic, mechanical obstruction of the small bowel, obstruction of the colon due to carcinoma and volvulus, and generalized peritonitis is discussed.

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J. MAXEY DELL, JR., Gainesville: Dr. Hurt, I enjoyed your presentation and consider it most timely. Knowledge of the possibilities of the scout film of the abdomen will result in increased utilization of this valuable diagnostic aid. There is one type of intestinal obstruction diagnosed by the radiologist which the clinician is hesitant to accept, namely, the so-called "no gas obstruction." In the average case with abdominal pain or a lesion in the abdomen there is usually a considerable amount of gas, and the absence of gas in this type of case should make one suspicious. In the upright film usually there is demonstrated a small amount of gas giving a fluid level in the small bowel and establishing the diagnosis. In strangulation obstruction there is excessive fluid in one or two isolated loops of small bowel with at times demonstrable edema of the walls of the bowel that lie against each other. This is important as it definitely contraindicates the use of decompression with the tube.

It is particularly important to diagnose a volvulus of the sigmoid or cecum for a cecostomy in this type of case is valueless and results in loss of the patient. Gas distending the large bowel in its right half coupled with a high white blood cell count is suggestive of a mesenteric thrombosis. Limited movements of the diaphragm with some pleural reaction plus a separation of the gas-filled stomach and colon may be of value in pointing to the possibility of pancreatitis.

Dr. Hurt did not have time to cover all the points and permitted me to make the additions. Thank you, Dr. Hurt, for a service to both the radiologist and the clinician.

Differential Diagnosis of Low Back Pain Based on a Study of Two Hundred and Eighty-One Cases

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Low back pain is one of the commonest complaints encountered in medical practice. In many cases the pain persists over long periods and fails to respond to treatment. Recently a large group of patients whose symptoms of back pain previously were undiagnosed has been found to have painful palpable nodules in the back. "Fibrositis" is the term commonly applied to this condition because the nodules were originally thought to be caused by fibrous tissue.

In 1944, Copeman and Ackerman,¹ two surgeons in the British Medical Corps, published the results of their studies of these nodules in patients and cadavers; they found that these nodules were actually herniations of fascial fat. In the cases I have studied their work was amply confirmed in the beneficial results of surgical removal of such subfascial fat hernias in a series of selected cases.² Since in this series of 281 cases a large proportion fall into this group with painful trigger points and nodules, or have actually been proved to have subfascial fat hernias, a study was made from the standpoint of differential diagnosis.

The most important factor in the treatment of severe low back pain is an exact diagnosis. This means that the known causes of backache must be sought in every case, since often there is more than one cause for the symptoms in the individual case. In making the diagnosis a detailed history is especially important. A history of some injury, such as a fall or strain, is present in the majority of cases; and often the onset of severe pain is attributed to some particular injury. It is important to find out the exact type of injury and its relationship to the pain of which the patient complains. A careful physical examination must be made, with thorough palpation to elicit trigger points of pain and painful nodules. Routine roentgenograms of the spine in all positions, anterior-posterior, lateral and oblique, must be made to determine whether disease or injury of the bone is present. If there is evidence of arthritis or other disease of the spine, attention

should be directed to this in treatment. Frequently, however, in such cases painful trigger points or nodules are also present. The symptoms are greatly relieved by anesthetic injections even when there is actual bony involvement. Even when palpable nodules are present, their removal should never be attempted until after a thorough therapeutic test with injections of anesthetic solution. If such injections do not relieve the pain, there is indeed little likelihood that an operation for subfascial fat hernia would be beneficial.³

Copeman and Ackerman¹ charted the distribution of the trigger points of pain in 50 consecutive cases (fig. 1) and found that it coincided almost exactly with the distribution of subfascial fat in the lumbar and lumbosacral area (fig. 2) in an anatomic study of 14 cadavers. In my series there were 86 patients subjected to this operation. Figure 3 shows the site of incisions made. The actual size of excised fat specimens is shown in figure 4. The specimen on the right shows gross evidence of strangulation. In this case the patient was a young woman, aged 28 years, whose symptoms were so severe that an emergency operation was necessary. Microscopic studies of the excised herniated fat (fig. 5) revealed evidence of a mild inflammatory process. Numerous publications on this condition

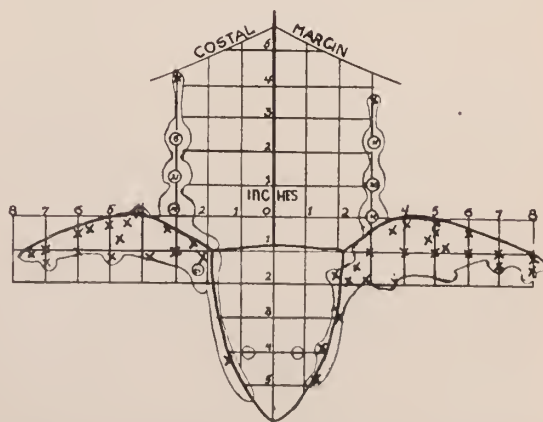


Fig. 1.—Distribution of trigger points of pain in 50 consecutive cases (from Copeman and Ackerman¹).

Read before the Florida Medical Association, Seventy-Sixth Annual Meeting, Hollywood, April 24, 1950.

have also been written by others,⁴ indicating that many patients with hitherto undiagnosed and undifferentiated back pain have obtained relief from this procedure.

In the management of patients with low back pain, it must not be overlooked that occasionally the cause of the pain is some internal disease, such as retrocecal appendicitis, kidney stones, or gallbladder disease. Hence, if a thorough investigation of the back and spine fails to account for the back pain, more general clinical and roentgenographic studies are required for a differential diagnosis.

Some of the many causes of low back pain are shown in the reports of the illustrative cases that follow.

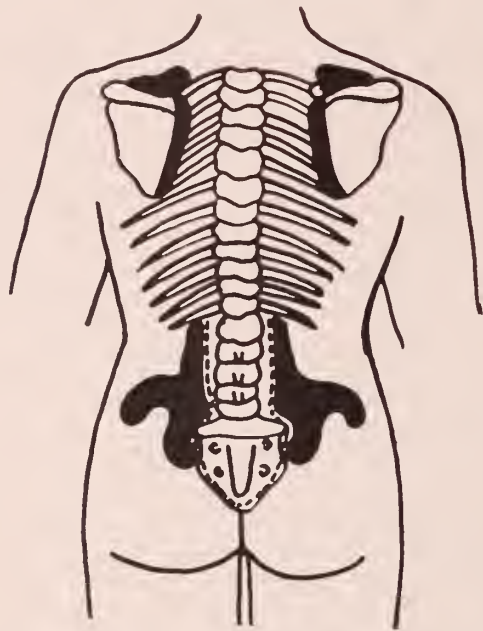


Fig. 2.—Distribution of subfascial fat in the lumbar and lumbosacral area (from Copeman and Ackerman¹).

Report of Cases

Case 1.—A woman, aged 34 years, had had recurrent attacks of lumbago for seventeen years. Roentgenograms of the lumbar spine showed advanced osteoarthritis. In addition, she had bilateral subfascial fat hernias which were treated surgically. The arthritis has not progressed materially since the operation three years ago, and she has had no further attacks of lumbago.

Case 2.—A nurse had injured her back six months before she consulted me. The pain was first felt after lifting a heavy patient. A roentgenogram of the spine showed anterior slipping of the fifth lumbar vertebra over the sacrum. A form-fitting support enabled this patient to return to duty.

Case 3.—A man had a disrupted intervertebral disk, as shown by the defect in distribution of radiopaque lipiodol solution. This procedure is necessary only when the exact situation of the disrupted disk cannot be determined by careful neurologic examination.

Table 1.—Clinical Diagnoses in 281 Cases of Low Back Pain

Subfascial fat hernia relieved by operation	86
Painful nodules relieved by anesthetic injections	82
Painful nodules with chronic arthritis of spine.....	36
Post-traumatic cyst pressing on sciatic nerve	3
Incomplete cases (relief following 1 injection of anesthetic solution to painful points, but no follow-up)	45
Undiagnosed (no relief from injection of trigger points and no other cause for backache revealed)	8
Disrupted intervertebral disk (2 also had subfascial fat hernias)	6
Tuberculosis of spine	1
Fractured coccyx	2
Incomplete fracture of lumbar spine	1
Spondylolisthes's (roentgenographic diagnosis)	3
Sacroiliac dislocation (roentgenographic diagnosis) ..	3
Retrocecal appendicitis	3
Renal calculus	2
Total	281

Case 4.—A woman, aged 43, had had a fall two years before I saw her. A routine roentgenographic examination disclosed a fracture of the coccyx and injury to the sacrum. In addition, she had a subfascial fat hernia. This was excised at the time of operation on the coccyx, and the patient obtained satisfactory relief.

Case 5.—A woman, aged 46, had suffered from severe backache for ten years, following a fall, and had been treated for "arthritis" without obtaining relief. About a year before I saw her, she had a second severe fall which greatly aggravated her pain. For several months she had scarcely been able to sit, and there was referred pain down the left leg. She had been advised to go to a sanatorium, under the supervision of a competent psychiatrist, since all therapeutic measures had failed and her physician had concluded the pain must be psychogenic. There was a trigger point of pain in the left sacroiliac region and a large palpable mass in the left buttock. This proved to be a case suitable for operation because complete relief was obtained by injections of 1½ per cent aqueous metylocaine* solution.

At operation, herniated fat was excised over the left sacroiliac region, and a large mass of dense fibrous tissue was widely excised through an incision over the left buttock. Examination of the specimen showed an organized hematoma with multiple hemorrhagic cysts. This was pressing on the sciatic nerve. The patient experienced complete relief from her disability and was able within a few months to make a 5,000 mile trip by automobile, without any recurrence of symptoms.

Case 6.—A man, aged 34 years, had had severe backache for fifteen months. A routine roentgenographic examination revealed a renal calculus. This finding was

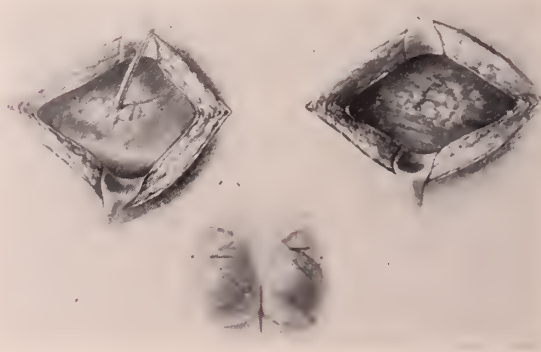


Fig. 3.—Incisions made for subfascial fat hernias.

verified by retrograde pyelograms. Because of the size of the stone, it was removed by open operation. The patient's recovery was uneventful, and he was relieved of his back pain.

Case 7. — In this case, routine roentgenograms showed nothing abnormal, and physical examination revealed no cause for the persistent backache of which the patient complained. Examination of the abdomen, however, revealed rebound tenderness which was elicited in the right lower quadrant. At operation a retrocecal appendix was removed, and afterward the patient's backache was completely relieved.

Summary

A discussion of the differential diagnosis of low back pain, based on a study of 281 consecutive cases, is presented (table 1). A large proportion of the patients in this series had painful trigger points or nodules in the back and were relieved by injections of anesthetic solutions. Eighty-six of these patients were subjected to operation for removal of herniations of subfascial fat. In 82, the symptoms were kept in good control by repeated injections of anesthetic solution, at intervals, and operation was deemed unnecessary. Thirty-six patients who had these painful nodules, in addition to chronic arthritis of the spine, obtained varying degrees of relief of pain following

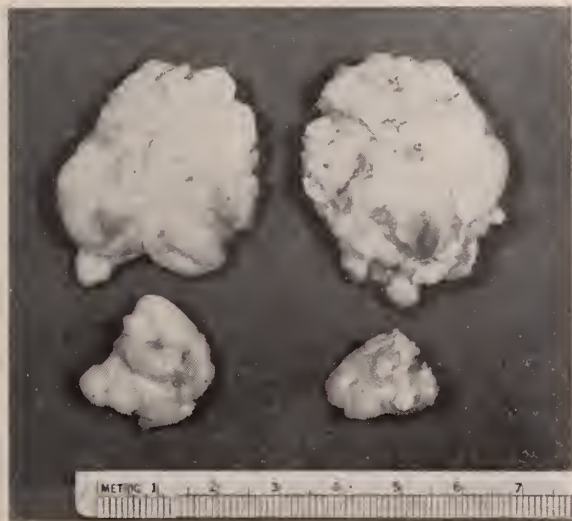


Fig. 4.—Actual size of excised fat specimens.

injections of anesthetic solutions.

Among other causes of low back pain in this series were: post-traumatic cyst pressing on the sciatic nerve, disrupted intervertebral disk, tuberculosis of the spine, fractured coccyx, incomplete fracture of the lumbar spine, spondylolisthesis, sacroiliac dislocation, retrocecal appendicitis and renal calculus.

Although the number of cases of painful nodules and subfascial fat hernias in this series is undoubtedly higher than it would be in other series

because many patients are referred to me because of my special interest in this condition, the large number of such cases suggests that perhaps many cases of so-called undifferentiated low back pain belong in this group. When painful nodules are systematically looked for, they are found in increasing numbers; and any patient who has had persistent low back pain should be subjected to such an investigation. If such nodules are found, the relief obtained from anesthetic injections, and,



Fig. 5.—Microscopic section of excised herniated fat showing mild inflammatory process.

in the more severe cases, from surgical removal of subfascial fat hernias, is striking. This treatment is, however, not a panacea for all types of backache, which, as the present report indicates, is traceable to many different causes.

*Since this paper was presented, I have used intracaine for injection in a number of cases of subfascial fat herniations with excellent results.

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Discussion

DR. FRANCIS W. GLENN, Miami: I am pleased to have the privilege of discussing Dr. Herz's excellent paper. In addition to discussing the differential diagnosis of backache, he has shown an excellent series of cases in which he found a subfascial herniation of fat. He has called attention in slides to this peculiar type of fat which is arranged in a more or less definite pattern in the lower back and has shown that this type of fat is different from the usual subcutaneous fat in this area. His emphasis on the role of this fat mass in the causation of back pain, and the method of making the diagnosis and the treat-

ment are, I believe, a definite contribution in helping to solve one of the baffling problems of backache. This condition is undoubtedly common, but has escaped us.

About ten or twelve years ago, Steindler of Iowa, and later Badgley of Michigan, emphasized the use of novocain as a diagnostic aid and therapeutic measure in the treatment of certain types of backache, which probably were the result of these lesions. They attempted to explain the radiation of pain on a theoretic basis that it probably was through the sympathetics. Repeated injections would sometimes effect a cure, together with physiotherapy and active exercise. Most of us have used injections as a diagnostic measure and a therapeutic measure in the past, without realizing the pathologic state Dr. Herz has described.

Since receiving his paper, I have had a case in which there had been a previous laminectomy, with relief of most of the pain down the leg. A defect was shown on the myelogram, and the defect was found and removed. The patient still had a painful area just above the posterosuperior iliac spine, and a nodule was felt there; the pain radiating down the outer side of the thigh to the knee was relieved by novocain injection. She was operated upon again, and a typical herniation of fat was found about the level of the third or fourth lumbar vertebra; this was excised. She had several smaller herniations below at the level of the posterosuperior spine of the ilium. These were also removed and the fascia closed over. The fascia in this area was thin, and the globules of fat, as Dr. Herz described them, were rather large globules, held together by thin connective tissue. There was some evidence of inflammation in this mass, but I thought this was due to the diagnostic puncture done two weeks previously. The fascia was thin and somewhat friable in this case, and the large defect was difficult to close.

Dr. Herz emphasized the necessity for good roentgenograms in cases of back pain. I think they are extremely important. More and more emphasis should be placed on the necessity of having at least an anteroposterior and a lateral view of the spine. Oblique views and stereo views, plus spot films when indicated, are often necessary to rule out, definitely, bony or joint pathologic change. A single anteroposterior view, even though of excellent quality, does not rule out bony or joint pathologic conditions when it is realized that this film is made through the spinous processes and all the other structures of the anterior portion of the body, and does not give sufficient information. Many fractures, not greatly displaced or even evident at all in the first films, will be missed if the lateral view is not made.

Cases of hemangioma of the vertebral body seem to be on the increase, undoubtedly because of better roentgenograms, including spot films, showing the finer detail as responsible for this discovery. The importance of proper positioning is of course self evident.

Protruded intervertebral disks were first described in 1934 by Mixter and Barr in Boston. Since that time thousands of cases have been reported and many patients operated on with good and indifferent results, and sometimes with bad results. Protruded disks in industrial cases are always a headache. We have 1 case now in which there is a large defect between L4 and L5, L5 and S1, and a smaller one between L3 and L4. This man has one of the most striking defects that I have ever seen, and still his ankle jerks are active and equal, as well as the knee jerks. There are only vague sensory changes. Pain is in the right leg and not in the left, in spite of the bilateral defects. I found a mass just below and medial to the posterosuperior iliac spine, which was extremely tender and caused pain clear down to the foot. This was infiltrated with novocain, and when this mass was struck, he said the pain shot all the way down to the foot. The pain was relieved following injection, and he volunteered that instead of having pain there he had a numb feeling. This treatment was just given recently and, since this is an industrial case, surgery has been postponed. Incidentally, this patient shows a typical sciatic scoliosis, as seen in a ruptured disk.

Again, as Dr. Herz emphasized, the patient is a whole animal and has to be considered as such, and many pre-existing problems which did not up to that time give pain, may be aggravated by injury, illness, fatigue or any other cause that may lower resistance. One of the difficult problems to evaluate is the industrial or liability case, in which injury has been superimposed on pre-existing arthritis. In some cases of this type, the best cure, of course, as we all know, has been a greenback poultice.

I want to thank Dr. Herz again for the privilege of discussing his excellent paper, and I believe that he has made a definite contribution in the solution of the problem of back pain.

DR. HERBERT W. VIRGIN, JR., Miami: The major question raised in Dr. Herz's paper is difficult to approach. The reason is that there is a great multiplicity of diagnoses available in the study of back cases. This great number is evident to anyone who has done any amount of back work. Dr. Herz's diagnosis of encysted fat pads as the major finding in painful backs in such a large percentage of cases seems to make back work look simple, and I think it is incumbent upon someone who does a great deal of back work to point out that it is really not quite so easy as he has made it appear.

Several years back I reported to a staff conference 2,750 back examinations in the previous twelve years of experience. I can honestly say that the finding of painful nodules as the prime cause of back pain in any one case was so negligible in its percentage that it dropped down to the bottom of the list as a diagnostic entity in this presentation.

There is no doubt that Dr. Herz is correct on one point. That is that injections of novocain will give relief and will give great relief in the cases in which painful nodules are actually the primary cause of back pain, but we have to stop and think that the pressure of the examiner's fingers over the area of normal tissue will give pain in a painful back. Then we add to this thought that pressure upon a globular mass of fat exactly over an underlying tender area which ordinarily would respond with pain to the pressure of an examining finger will produce more pain because the concentration of pressure over a globular mass will give a more concentrated and smaller area of pressure. The idea is that in such cases we will get painful responses anyway whether the fat is there or whether it is not there, and it is not the mass of fat that causes pain in these cases. It is almost impossible to differentiate between cases of this sort and cases in which the mass of fat itself becomes the primary painful mechanism.

There have been only a few instances in my own experience in which masses of encysted fat themselves have caused back pain. I am glad that Dr. Herz has had such exceedingly good results with his cases, and it is wise for him to have brought this factor in the production of back pain to our attention, and to have given us such good technic to follow in the application of novocain. It is just as wise to remember that many causes of back pain may exist in the presence of fat globules, and these should all be ruled out by accurate differential diagnosis before it is determined that the globules themselves are the cause of pain.

DR. HERZ, concluding: Dr. Virgin's point is well taken, but what I do when I first examine the patient is to ask the patient to put his finger on the point of pain, and the patient is usually able to find it.

There is one point that I should like to emphasize and that is that I do not use novocain. Procaine has come into general use, but in many people there has developed an allergy to procaine. It is perfectly safe to inject metycaine solution, 1½ per cent, which is used as an anesthetic, provided you do not inject it under pressure.

In closing, I should like to point out that in the past we have always been looking for the cause of back pain in the bone, and while in many cases this is the correct place, there are many cases in which one or more injections into a mass of fat will produce relief.

Parathion Poisoning

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LAKELAND

The last several months have witnessed many cases of parathion poisoning in the state of Florida, with 1 death. While this insecticide, *o*, *o*-diethyl *o*-*p*-nitrophenyl thiophosphate, is of economic importance for crop protection, measures necessary for protection of man at times have not been taken, have not been understood, or have been neglected. To date there have been at least 6 deaths from parathion poisoning, and many cases of varying degree of severity with recovery.

As little as 0.3 Gm. daily exposure has been estimated as dangerous to man, and as little as 12 to 20 mg. may be considered as a quantity apt to prove fatal.¹

Parathion is a cholinesterase inhibitor through which action acetylcholine accumulates at the synapses, producing the symptoms. It affects the muscles and glands, producing a muscarinic effect manifested in cases studied by gastrointestinal, respiratory, ocular and dermal symptomatology. It also has a nicotinic effect on the heart, blood vessels and muscles and a paralyzing action which may occur in the presence of high concentrations.

Cholinesterase inhibitors and the parasympathomimetic drugs produce a common symptom complex. To this class belong physostigmine and prostigmine. Parathion and the other phosphate esters, however, act in relatively minute amounts, possibly only 2 to 3 mg. a day for three days in some instances resulting in almost complete destruction of plasma and red blood cell cholinesterase. As a result of destruction of cholinesterase, acetylcholine is not destroyed. Drugs in its class are muscarine, pilocarpine, mechoyl and doryl.

Normally red blood cells, plasma, and tissue enzymes hydrolyze acetylcholine. The plasma cholinesterase is inactivated by the organic phosphate ester and may approach zero activity and that of the red blood cells 10 per cent activity before symptoms appear. Symptoms have disappeared when the red blood cell activity has returned to 10 per cent.²

A person who has repeated exposures to parathion may become unusually susceptible since his cholinesterase is low and relatively small quantities of parathion are necessary to reduce it to the danger zone. Final recovery of cholinesterase takes about three weeks for plasma and three months for red blood cells and probably tissue. The recovery of plasma appears to depend on liver function and of red blood cells on their formation.

Symptomatology

Parathion is described as having both a muscarinic and a nicotinic effect. A review of the symptoms in 30 cases indicates that a clear-cut picture of these effects is sometimes difficult to obtain. This difficulty probably arises because of rate of absorption, route of absorption, concentration of parathion, existence of peculiarities in the individual and sensitization. Table 1 shows the number of cases in which the various symptoms were present, arranged in accordance with the area affected.

Diagnosis

The diagnosis of the average case of parathion poisoning should not be difficult. A history of exposure is of prime importance. Heat, humidity, length of time of exposure, concentration exposed to, route through which absorption takes place and age of the patient are of importance. Absorption is especially good and effects especially pronounced when exposure occurs on hot humid days. Vulnerability through the respiratory tract is four times as great as through the skin. Exposure over a long period of time to small quantities may mean that the cholinesterase level in the blood is low and that small subsequent exposures may reduce it to a level where symptoms of poisoning will occur. With age there is reduction in physiologic reserve and regenerative processes which may make the older person more sensitive to poisoning. Anemia and disease of the liver may interfere with cholinesterase production and regeneration, and continued exposure may result in exhaustion of the

mechanism. Persons vary with reference to sensitivity to phosphate esters, and those especially sensitive in this respect should not be allowed to work with the substances.

The different types of effects of parathion are amply illustrated in Table 1.

Table 1

Signs and Symptoms	Number of Cases
Chest and respiration	
Constriction chest pain on exertion	1
Edema of lungs and bronchi	7
Labored breathing	5
Pain in chest and arms	1
Ears	
Ringings	2
Eyes	
Blurred vision	4
Constricted pupils	14
Glassy eyes	1
Gastrointestinal tract	
Abdominal cramps	16
Desire to defecate	1
Diarrhea	1
Involuntary defecation (1 also micturation)	5
Nausea	17
Salivation	1
Vomiting	14
Muscles and tendons	
Heavy feeling muscles in arms and legs	1
Loss of tendon reflexes	2
Muscle incoordination	1
Spasm of muscles	1
Stiff and aching muscles	1
Twitchings, local as tongue and eyelids	3
Twitchings, muscles in general	6
Nervous system	
Anxiety and apprehension	5
Confusion	1
Convulsions	4
Dizziness	11
Grogginess	2
Headache	9
Mental sluggishness	1
Paresthesias	1
Slurred speech	3
Stupor, coma	13
Skin	
Cold and chilly sensation	6
Sweating	6
Warm	1
General	
Collapse at work	1
Cyanosis	8
Objects heavy to lift	1
Tired feeling	1
Tremulous	1
Weakness	5

Gastrointestinal symptoms are most frequent, but appear to carry the least serious import. Edema of the lungs, severe effects on muscular and vascular systems and severe symptoms of the central nervous system carry the most serious import. Of the 6 deaths, edema of the lungs was the most constant finding at autopsy.

From the data at hand it appears that death might be expected to occur within twenty-four hours after the beginning of symptoms. The short-

est time was eight hours. The time for recovery may range from four hours to four weeks.

Estimation of the cholinesterase activity of the plasma and blood is of prime importance in the diagnosis. It is most easily understood when recorded as percentage activity. Depression of plasma esterase by 75 per cent or more, or of red blood cell esterase by 40 per cent is good evidence of recent absorption of a cholinesterase inhibitor such as parathion.³

Precautions

Pamphlets on parathion poisoning are distributed by the American Cyanamid Company. Poor water solubility, good lipid solubility and slow hydrolysis account for its properties. Does a sufficient amount remain on fruits and vegetables after spraying to cause poisoning? As yet there are no recorded cases.⁴

Cholinesterase shows decrease with anemia, low plasma protein and exposure to an inhibitor. Individual values are comparatively constant (normal range 75 to 125 per cent). Depression of plasma cholinesterase of 20 per cent suggest recent exposure. A red cell cholinesterase reduced to 60 per cent of normal (or symptoms at a somewhat higher level) warrants immediate withdrawal from exposure until regeneration. Plasma cholinesterase is an index of exposure but not for withdrawal.

The anticoagulant for blood samples is heparin. Blood from a vein is preferable, but ear or finger tip blood can be used providing the capillary tubing first has been rinsed with heparin.

Treatment

Removal of parathion from the skin, stomach and intestinal tract is done in prescribed fashion. Atropine is given as a physiologic antidote to the muscarinic effects, namely, gastrointestinal, respiratory, visual, sweating and salivation. Magnesium sulfate is used as a peripheral muscular depressant guarding against respiratory failure by use of calcium gluconate. Postural drainage is instituted for drainage of secretions collecting in the mouth and respiratory tract, and aspiration is done when necessary. Oxygen inhalations are routinely employed for cyanosis and respiratory distress. Artificial respiration may be necessary when the case assumes aspects resembling bulbar poliomyelitis. When the cholinesterase proves unduly low, transfusions of fresh blood are recommended. Other symptoms are combated in accordance with routine procedures.

Conclusion

Parathion probably will have increased use because of its economic value as a spray. The public and workers will have to be educated more widely as to its dangers, and strict discipline will have to be instituted to insure that all the necessary precautions are taken to prevent poisoning.

Parathion is toxic only in so far as it destroys cholinesterase, which in turn destroys acetylcholine. When the acetylcholine reaches dangerous concentrations, symptoms occur.

The symptomatology is varied and unpredictable. Prompt treatment is necessary.

Cholinesterase studies should be made in all cases in which poisoning is suspected, and periodically on workers with the substance. Other cholin-

esterase inhibitors will increase susceptibility to parathion poisoning.

The respiratory is cited as the most dangerous route of absorption.

I wish to thank the following for their cooperation: Dr. David Grob of the Johns Hopkins Hospital, Drs. D. O. Hamblin and J. F. Marchand of the American Cyanamid Company, Dr. J. B. Redd of Florida Southern College, Dr. J. T. Griffiths and C. R. Sterne of the Citrus Experiment Station, Drs. J. W. Annis and Henry Fuller of Lakeland, and Drs. R. D. Fields, N. J. Griffith and W. T. Steele of Winter Haven.

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P. O. Drawer 873.

Two Medicolegal Case Reports: Cerebromalacia Following Puncture Wound of Neck with Anomaly of Circle of Willis; Pulmonary Air Embolus from Attempted Self Abortion

THOMAS W. HUTSON, JR., M.D.

MIAMI

With the recent growth of Dade County from 42,753 in 1920 to 550,000 in 1950, legal autopsies are coming into importance. The department of pathology at Jackson Memorial Hospital averages 600 to 700 autopsies a year. Of these, 34 per cent are legal autopsies. With this fact in mind, 2 cases of interest not only to legal medicine but also to the general practitioner are presented.

Cerebromalacia Following Puncture Wound of Neck, Anomaly of Circle of Willis

Case 1.—H. C., a 60 year old white man, was admitted to Jackson Memorial Hospital in profound shock due to external loss of blood. He had been stabbed in the neck with a pitchfork during an altercation thirty minutes prior to admission.

Physical examination revealed a well developed, well nourished man of stated age in extremis. His clothes and the left side of his face were covered with freshly clotted blood. The blood pressure on admission was 80 systolic and 40 diastolic. The pulse rate was 100 and regular. There were two puncture wounds on the left side of the neck, one at the left auditory meatus and the other slightly anterior to the middle third of the sternomastoid muscle. These puncture wounds were 5 mm. in diameter with a trickle of blood oozing from them. There was pronounced distention of the left side of the neck, and the trachea was deviated 1 inch to the right of the midline. The reflexes were normal; however, there was no movement of the right

extremities. The left extremities moved freely. Only with extreme stimulation was there movement of the right limbs. The pupils were equal and responded to light.

Shock therapy was instituted, and the blood pressure rose to 160 systolic and 90 diastolic. The patient remained comatose, and the wounds began to bleed freely and profusely. The bleeding could be controlled by local pressure on the carotid vessels.

Roentgen examination revealed no foreign body in the region of the neck. The red blood cell count was 3,900,000; the number of white blood cells was normal. Urinalysis gave negative results.

On surgical exploration of the left side of the neck, a large hematoma was evacuated, and the carotid sheath was exposed. Inspection of the left common, internal and external carotids revealed no perforations. A small branch of the left external jugular vein was perforated. This was ligated, and the bleeding ceased. The wound was loosely closed, and a rubber drain was left in the fascial spaces. The trachea had now returned to normal position. Blood pressure at this time was 145 systolic and 80 diastolic.

The patient remained in coma. There was movement of the left extremities, but none of the right extremities. The reflexes remained normal. The eyes were rotated to the left and fixed in this position. Cheyne-Stokes respiration developed. There was a gradual rise in temperature to 106 F. on the second day of admission, at which time he expired.

AUTOPSY.—Postmortem examination revealed the body of a 60 year old white man with a surgical dressing over the left side of the neck. A small perforation 3 to 5 mm. in diameter was noted in the inferior portion of the left auditory canal.

From the Department of Pathology; Dr. Philipp R. Rezek, Director, Jackson Memorial Hospital, Miami.

The left side of the neck was markedly swollen. The overlying skin presented a bluish black discoloration. The swelling extended from the left mastoid prominence down to the clavicle and from the midline to the left posterolateral aspect of the neck. There was a T-shaped surgical incision on the left side of the neck with a rubber drain protruding through the incision. The cross of the T, 5 cm. long, extended over the middle portion of the left mandible. The erect portion of the T, 10 cm. long, extended from the mandible downward over the region along the carotid sheath. The incision had been carried through a 3 to 5 mm. perforation over the carotid sheath.

On dissection of the left side of the neck, the muscles and fascial planes contained a large amount of extravasated blood causing great distention of all structures. There was no definite localized clot. The trachea and larynx were displaced to the right of the midline. The common carotid artery was isolated and opened. There were no perforations. The internal and external carotids were normal. The internal jugular vein was intact. In the external jugular system, a medium-sized branch, that had been transected, was ligated.

The scalp, skull and dura appeared normal. Upon removal of the dura, a left subarachnoid hemorrhage, 2 mm. thick, was seen. The brain weighed 1,500 Gm. The entire left cerebral hemisphere had undergone pronounced malacia. Inspection of the circle of Willis revealed absence of the anterior communicating branch and a threadlike left posterior communicans. The cut surface of the left anterior and middle cerebral hemispheres revealed complete malacia. The posterior portion was somewhat softer than the right cerebral hemisphere. There were hemorrhagic areas throughout the entire left cerebral hemisphere.

The mediastinum contained some dark red blood infiltrating its upper structures.

The heart showed a moderate left ventricular hypertrophy and weighed 400 Gm. The coronary vessels contained several small, raised, yellowish, calcified plaques in the intima.

The kidneys had a fine granular atrophy of the cortex.

The remaining organs were grossly normal.

Gross Diagnosis: Pronounced malacia left cerebral hemisphere; left subarachnoid hemorrhage; absent anterior communicating branch of the circle of Willis; threadlike left posterior communicans of the circle of Willis; hematoma, left side of the neck; compression of the great vessels of the left side of the neck with displacement of the trachea and larynx to the right; and surgical incision, left side of the neck.

The incidence of anomalies of the circle of Willis is more frequent than the normal. In 200 cases at autopsy, Fetterman and Moran¹ found less than 50 per cent of the normal anatomic circles of Willis. Of these 200 cases, 23 per cent showed anomalies of the posterior communicating branches. Of these 46, or 23 per cent, there were 20 examples of threadlike posterior communicans of one or the other posterior communicans. There were 16 cases of bilateral threadlike posterior communicans. Absence of one posterior communicans was encountered six times. There were 3 cases of absence of one posterior communicans with threadlike formation of the other. There was 1 case of absence of both posterior communicans. In no case was an absent anterior communicans encountered. The incidence of anomalies was more frequent in women. In men, 159 cases, 32 or 20.1 per cent showed anomalies; in women, 41 cases, 14 or 34.1 per cent showed anomalies. Fawcett and

Blackford,² in 700 cases, reported the same sex incidence as Fetterman and Moran.¹ They also corroborated the latter's report on the incidence of percentage of anomalies. They reported that threadlike formation of the left posterior communicans is the most frequent anomaly of the circle of Willis, occurring 86 times, or 17.0 per cent, in 510 cases. Absence of the anterior communicans was reported in 1 case of a series of 1,300 autopsies.

The anatomy of the circle of Willis is too well known to be discussed here. The collateral circulation of this circle following ligation of the common carotid artery, however, should be discussed. After ligation of the common carotid artery, the circulation is carried on through: (1) the opposite internal carotid; (2) the circle of Willis; (3) the angular with the ophthalmic; and (4) the internal carotid on the side ligated, by means of retrograde flow down the external carotid and past the bifurcation. This reversal results from the following anastomoses: (a) the inferior with the superior thyroid; (b) the deep cervical branch of the costocervical trunk with the descending branches of the occipital and vertebral; (c) the superior thyroid, the lingual, the facial, occipital and temporal, with the corresponding arteries of the opposite side. With this anatomy in mind, it is obvious that ligation of the internal carotid is more dangerous than ligation of the common carotid.

Dorrance³ stated that a moderate percentage of cerebral complications following carotid ligation is due to reduced blood supply in which anomalies of the circle of Willis are present. Zehnder⁴ reported a case of a missing anterior cerebral artery found on arteriogram.

In the present case absence of the anterior communicans and threadlike formation of the left posterior communicans of the circle of Willis have been described; ligation of the great vessels was affected by pressure from the massive infiltration of blood into the fascial planes and muscles of the left side of the neck. This pressure was so great it displaced the trachea and larynx to the right of the midline. It was exerted not only on the left common carotid, but also on the left internal and external carotid, thus cutting off one of the largest collateral circulations. The absence of the anterior communicans and threadlike left posterior communicans left a large portion of the left cerebral hemisphere totally occluded of blood supply, resulting in anemic infarction and great malacia. This condition was observed clinically and at autopsy.

With regard to the importance of autopsy in such a case as this, the establishment of a pre-existing pathologic change cannot be overemphasized, as stressed by Rezek.⁵ Had the autopsy not revealed a pre-existing pathologic condition, as described, the defendant would have been indicted for first degree murder.

The frequency of anomalies of the circle of Willis and its importance to ligation of the carotid vessels in traumatic surgery and neurosurgery should not be overlooked or disregarded.

Pulmonary Air Embolus from Attempted Self Abortion

Case 2.—O. W., a 24 year old white woman, was admitted to Jackson Memorial Hospital on Nov. 26, 1949, dead on arrival. A history was elicited from relatives and close friends of the deceased.

This unmarried woman had her last menstrual period on July 23, 1949. There was no previous history of pregnancy or missed menses. On November 26, the deceased entered the lavatory at home and locked herself in. About ten minutes thereafter her father heard her scream and fall to the floor. He forced open the lavatory door and found her lying on the floor, gasping for breath, foaming at the mouth and clad only in a brassiere and skirt. She expired within a matter of two or three minutes. Homicide investigation revealed no evidence of trauma or foul play. The investigators noted a large douche syringe, with a small tip, filled partially with soapy water, lying on top of the toilet.

AUTOPSY.—External examination revealed the body of a well developed, well nourished white woman of stated age. There was a profound cyanosis of the nail beds, mucous membranes and conjunctiva. There was a large amount of white frothy and clear serous fluid present in the nose and mouth. The abdomen was slightly protuberant, and the uterus was palpated 5 fingerbreadths above the symphysis pubis.

Thoracic examination disclosed about 100 cc. of clear straw-colored fluid in both pleural spaces. There were many petechial hemorrhages over all the visceral pleura of the right and left lung. On the cut surface of the lungs there was a great increase in frothy blood-tinged material exuding from the parenchyma. There was great congestion of the vascular tree. The tracheobronchial tree contained a large amount of foamy, frothy material. The right lung weighed 750 Gm. The left lung weighed 500 Gm.

On opening of the pulmonary artery, a red frothy bubbly content was noted. The right atrium and ventricle contained the same type of material. Small gas bubbles could be seen through the inferior caval wall. On opening of the inferior vena cava, the bubbles were not mixed into a frothy substance as in the right side of the heart and pulmonary artery. There was no discernible air in the left atrium or ventricle.

The uterus was enlarged 5 fingerbreadths above the symphysis and was symmetric. It had a soft, boggy, crepitant feel on palpation. The myometrium was hypertrophied, and a fetus and placenta were present in the uterine cavity. The cavity itself appeared to be larger than the contained products of conception. The fetus measured 16 cm. from crown to heel. The placenta was 12 cm. in diameter, was implanted on the left anterolateral wall and was separated from the wall along its inferior border.

Diagnosis: Pulmonary air embolus.

Forbes⁶ stated that when any large vessel under less than atmospheric pressure is opened and cannot collapse owing to rigidity of its walls

or fixation of its wall, the entry of air is possible and its mechanism easily understood.

Under these conditions air embolism may result from (1) operations or lacerations of any great venous vessels, particularly in the neck and groin; (2) severance of dural sinuses during operation on the skull; (3) air entering the uterine sinuses during labor, following delivery and up to twelve days postpartum, and (4) during thyroidectomy.

When air is under pressure, air embolism may occur during (1) antral lavage, (2) distention of the bladder or urethra with air, (3) ureterotubal insufflation, (4) perirenal insufflation, (5) pneumoperitoneum, (6) pneumothorax, and (7) administration of air during intravenous administration. Vaginal douching during pregnancy and attempts at self abortion by douche syringe may also cause air embolism.

The mechanism of air embolism is not fully understood. Forbes⁶ concluded that the effects depend on whether the pulmonic or systemic circulation is involved. In the former case, the air collects in the right auricle and ventricle, and air emboli are impacted in the pulmonary arterioles. If the volume of air is large and it enters the circulation quickly, death takes place rapidly. If the volume of air is smaller or its entry slower and life is prolonged, the air blocking the pulmonary arterioles is absorbed partially. The remainder may escape through the capillaries and veins, thus finding its way to the left side of the heart and into the systemic circulation, to produce cerebral and coronary infarctions.

Teare⁷ reported a case of an 18 year old white woman who used a soap solution to abort herself at four months' gestation, with resulting pulmonary air embolus and sudden death.

Killinger and Collins⁸ reported a case of pulmonary air embolus with autopsy in a 40 year old white woman pregnant seven months. Air in a douche bag with a closed system and the nozzle inserted into the cervix, after which pressure was applied to the douche bag, caused pulmonary air embolism and sudden death.

Reynolds and Cutler⁹ in 1934 reported a case of air embolism following attempted abortion with a douche syringe. Subsequently they collected a series of 49 cases of air embolism from attempted abortion.

Deadman¹⁰ analyzed 4 cases of pulmonary air embolism resulting from attempted abortion. Several different solutions were used; however, the air

present in the syringes, due to poor precaution, was the cause of death.

Breyfogle¹¹ reported a case of pulmonary air embolus resulting from vaginal powder insufflation in an eight months pregnant Negro woman.

Vance¹² reviewed a case in which lysol was injected into the uterus as an abortifacient, with resulting pulmonary oil embolism, lysol poisoning and death.

Leditznig¹³ reported a case of fatal pulmonary air embolism following attempted abortion.

Decoulx and Bedrine¹⁴ described an unusual case of pulmonary air embolism following intra-uterine injection of soap suds. An emergency hysterectomy was performed, and the patient recovered.

Finn,¹⁵ writing on the occurrence of air embolism in gynecology and obstetrics, reported a case of air embolism following uterotubal air insufflation.

In this case the cause of death was evidenced by the admixture of air with the blood in the right auricle, ventricle and pulmonary artery. The free gas bubbles were also noted in the inferior vena cava. The cyanosis, separated placenta and other findings at autopsy substantiate the diagnosis of pulmonary air embolism.

The importance of air embolism occurring during pregnancy should be kept in mind. Vaginal douching during pregnancy should be done only with extremely low pressure and care should be exercised to remove air from the douche system. Forbes⁶ reported a case of fatal air embolism resulting from vaginal douching in which the woman was unaware of being pregnant. He also stated that air embolism may result during labor, after delivery and up to twelve days afterward. Stroh and Olinger¹⁶ reported a case in which pulmonary air embolus occurred during knee-chest exercise on the seventh postpartum day.

The amount of air necessary to cause death is a point of great discussion. No author has mentioned the exact or average amount needed. Coles, Richardson and Hall¹⁷ maintained that 480 cc. of air is required for fatality, while Simpson¹⁸ claimed that even 10 to 15 cc. of air may cause death.

Summary

A case is presented with two anomalies of the circle of Willis, (1) absent anterior communicans and (2) threadlike left posterior communicans, in which death was due to pressure ligation on the common, external and internal carotid arteries by hemorrhage following a stab wound of the neck.

The literature is reviewed covering the incidence and types of anomalies of the circle of Willis.

Case 1 represents one of the extremely rare reports of absent anterior communicans in the literature that was available.

The collateral circulation of the brain is discussed, and the contraindication to ligation of the internal carotid is emphasized.

The importance of medicolegal autopsies is mentioned.

A case of fatal pulmonary air embolism following attempted self abortion with soap suds, during the fourth month of pregnancy, is presented.

The mechanism and cause of pulmonary, cerebral and coronary air embolism, including the corresponding literature, are reviewed.

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ABSTRACTS OF MEDICAL ARTICLES

OVERPROTECTION: WILL IT MEAN THE END OF CIVILIZATION AS WE KNOW IT? By James L. Anderson, M.D. South M. J. 43:20-23 (Jan.) 1950.

In his chairman's address before the Section on Neurology and Psychiatry of the Southern Medical Association last November, Dr. Anderson deplored dangerous trends of today. Finding the nation with moral and spiritual resources not at all in keeping with the material advances and with an authoritarian tradition discouraging free thinking and analysis, he was not surprised that certain pathogenic micro-organisms have penetrated the national body. Two of the most virulent of these organisms he described: Pathogen 1. A person needs something. Therefore we must give it to him. Pathogen 2. One person has more than another. Therefore, that person should have it taken from him because of the needs of a more inadequate group.

In conclusion, this author observed: "The only constructive idea I can advance is that we should revert to some extent at least to the primitive and put a little trust in ourselves, and not in the beneficence of a bankrupt government. We should assume individual responsibility for our inadequacies and try to compensate for them by attaining higher and higher levels of productivity and service."

PRESACRAL ENTEROGENOUS CYST. By C. Lari-
more Perry, M.D., and James W. Merritt, Jr.,
M.D. Ann. Surg. 129:881-889 (June) 1949.

A case of enterogenous cyst located in the presacral area is described, and a review of the 10 cases of histologically proved enterogenous cyst reported in the literature as occurring below the peritoneal reflexion is presented. The three theories advanced to explain this type of cyst are briefly outlined, and the pathology is discussed. These authors join the other authors in advising removal and observe that removal of the cyst usually can be accomplished by the removal of the coccyx in a posterior approach.

RECURRENT SMALL INTESTINAL INTUSSUSCEPTION IN CHILDREN. By M. D. Teitelbaum, M.D., and Nathan Arenson, M.D. Am. J. Roentgenol. 63:80-88 (Jan.) 1950.

Five cases of intussusception of the small intestine are reported, and roentgenograms relating to 4 are reproduced. These 4 cases represent a type occasionally observed by pathologists, rarely by surgeons and, to the authors' knowledge, not hitherto demonstrated on roentgenograms.

The authors concluded that this anomaly occurs more frequently in young children than is commonly believed, that it is presumably a manifestation of neuromuscular dysfunction and, in some instances, may be an allergic response; that the intussusception, transient and recurrent in character and usually involving multiple segments of the small intestine, produces intermittent abdominal pain with nausea and sometimes vomiting, and that the symptoms may be present for months or years. Although single attacks may be severe, there is no strangulation or obstruction, they noted; no tumor masses can be felt, and there is no bleeding from the bowel.

THE PUBLIC HEALTH LABORATORY DIAGNOSIS OF ENTERIC INFECTIONS. By Mildred M. Galton, Albert V. Hardy, and Roland B. Mitchell. Am. J. Trop. Med. 30:77-90 (Jan.) 1950.

A method for the isolation and identification of *Shigella* and *Salmonella* from fecal specimens is described. For convenience in performance the procedure is set up under five main divisions. The first, planting, consists of direct inoculation of the specimen as received, to selective plating media and an enrichment broth. The second and third, screening and presumptive serology, involve the inoculation of differential triple sugar medium, and rapid biochemical tests followed by slide agglutinations with various polyvalent antisera. The fourth step is biochemical confirmation and the fifth serologic identification. The authors observed that the simple screening and presumptive serologic tests adopted reduce to a minimum the number of organisms requiring further biochemical and serologic study for complete identification.

COMPLICATIONS OF ANTICOAGULANT THERAPY.

By George D. Lilly, M.D., and Robert M. Lee, M.D. Surgery 26:957-967 (Dec.) 1949.

Ten cases are described in which anticoagulant therapy was used. In 5, serious postoperative complications ensued, and the remaining 5 terminated fatally. Study of this series led the authors to conclude that there are no reliable laboratory procedures for the estimation of prothrombin levels and that Dicumarol is a hazardous therapeutic agent at best since its use in postoperative treatment may cause sudden, severe and even fatal hemorrhage, even when carefully controlled by experts.

In their opinion there is no justification for the employment of anticoagulant therapy in cases of phlebothrombosis and thrombophlebitis limited to the lower extremity below the groin, because proper vein interruption is a more certain, much safer, quicker, and much less expensive method for the control of this condition. Rather than the prophylactic use of anticoagulants, fraught as it is with hazards, they favor correct bed posture and properly supervised exercises to accomplish the same prophylactic results safely and economically.

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Unhealthy Britain

There have been many reports from Britain during the past few years, all of which seem to point in the same general direction. Conclusions of the five man A. M. A. Committee to Study Medical Care in England make it clear that the tremendously expensive experiment carried out under the National Health Act has degraded the practice of medicine and failed to improve the health of the British people.

Some analysts have pointed out that in Britain today there is no question about the warm reaction of the man in the street toward the service. "On balance, he reasons, things are much better than before July 1948. As long as Nye Bevan can go on raising taxes for it, the National Health Service will be a boon to him, the missus, and the kids."

Dr. Marion F. Beard, Louisville hematologist who recently returned from England after addressing the International Society of Hematologists at Cambridge University, suggested to the press that Britain's national health scheme be left out of arguments about similar legislation for this country. Said Dr. Beard: "Medical needs of England cannot be compared with those in this country. . . . Ability to pay for medical care is much lower in England than in this country. . . . Also, before England's present program there were no hospitals comparable to our city hospitals or our Veterans Administration hospitals. Charity patients in England were treated in private hospitals if authorities approved admittance. . . ."

Dr. Beard did not tell us: that even if all the dental schools were doubled, it would take twenty-five years to provide Great Britain with enough dentists; that five prescriptions have been issued in Lanarkshire for every person in the county since the Health Service started; and that a recent newspaper headline proclaimed, "10,000 Queue for Hospital Beds."

We shall follow Dr. Beard's suggestion for the present and leave Britain's national health plan out of our remarks. Let us ponder these British items which come from unimpeachable sources:

Almost everything Britain has nationalized has incurred losses, requiring heavier taxes.

Nationalized "hostels" lost over \$25,000,000 last year.

Automobiles are unobtainable, even after ordering for several years.

Britain is making it difficult for those who already own automobiles to operate them for any appreciable length of time.

There is business ineptitude. Clerks in the shops seem indifferent and supercilious and are surprisingly inefficient.

So reckless have the British people become that last year the amount of money spent on sheer gambling — horse racing, football "pools," dog races, and the like — amounted to \$40 for every man, woman and child in the nation. Britons spend more on gambling than on clothes.

Omitting the health angles from our remarks entirely, we still do not hesitate to conclude that Great Britain is in an unhealthy state. She has rendered us service in that she has shown us the pitfalls which we should do well to avoid. Those who would have us change from our American way of life do us a great disservice.

Surgical Sonatas

"Music hath charms to soothe. . ." has its practical application today as an aid to anesthesia in operations. The use of music to soothe the surgical patient is styled "surgical sonatas" by the staffs of the University of Chicago hospitals and clinics, where it is no longer an innovation.

Beethoven or Brahms? Berlin or Bing? The anesthesiologist usually inquires the night before the operation regarding the patient's preference for classical, semiclassical or popular selections, both before and during the operation. Children have their choice, too, and may receive music from Peter and the Wolf, Cinderella, Pinocchio, or scores of other nursery favorites.

As the patient is prepared for the operation, the music begins coming in softly over the wall speaker and later over the headphones. Fitting tiny personal earphones to a patient on the operating table is now part of the standard routine of anesthesiologists working under Dr. Hulberta M. Livingstone, head of the anesthesia department. The musical program is the joint secret of the anesthesiologist and the patient, for others in the room do not hear it. The anesthesiologist monitors the program with earphones and attaches the headset to the patient.

The whole idea developed from a chance remark made to Dr. Livingstone by a young war veteran audioengineer, Joel Willard, who thought soft music would be diverting to a restless patient and would drown out the sounds of the clicking instruments and the low conversation of the surgeons. With a research grant from the Navy, a trial installation was made in 1947. The music at once proved its worth as no novelty or frill but "a fundamental addition to the science of pain deadening." It has come to be regarded as indispensable in appendectomies, vagotomies and the other operations in which general anesthesia is not advisable. The extent of its application was emphasized recently when it was classed as standard equipment for all six operating rooms of the new Nathan Goldblatt Memorial Hospital.

The music comes from a master control room with three magnetic tape recorders. Each has its special type of music and plays continuously for hours without repeating. It would seem that surgical sonatas might well become widely popularized as a new vogue in hospital fashions.

How Old Is Old?

Faced with the unanswerable question, "How old is old?" the National Conference on Aging, held in Washington on August 13-15, nevertheless wrestled with some success with the problems associated with the increasing proportion of older persons in our population. Among the 808 delegates representing diverse professional fields and public groups, one opinion prevailing over all others appeared to be that to define age in term of years is meaningless, that retirement plans based on chronology are wasteful, blundering, full of long range dangers to the nation, and even capable of wrecking the nation's economy.

"Old age is always five years older than you yourself are," was one delegate's opinion. Another might have said twenty years older. It was Victor Hugo who aptly described 40 as the old age of youth and 50 as the youth of old age. So be age what it may, there was wide agreement among the delegates that instead of retirement at a fixed age, retirement plans must be tied to disability. But, what is disability?

This conference, called, organized and conducted by staff members of the Federal Security Agency, comprised 28 committees, grouped into nine sections, dealing with a wide range of subjects pertaining to the needs of older persons. The objective of this "national exploratory forum" was to set in motion an immense project of research to find the answers to the many unanswered questions.

The Section on Health Maintenance and Rehabilitation emphasized in its preliminary subcommittee reports: the need for study of characteristics of well adjusted older persons—the epidemiology of health as well as that of disease; greater accuracy in lay health education; more emphasis on geriatrics in medical education; caution in promoting multiple screening programs, still in the experimental stage; development of more facilities for providing services at home, now available only in hospitals or clinics; provision for senile patients with mild psychosis; formulation of basic standards for nursing homes; establishment of geriatric guidance centers; development of com-

munity facilities for group activity and recreation of older persons; and leadership of physicians and medical societies in developing integration of community agencies to provide a balanced program to meet the health needs of elderly persons.

The consensus of the conference was, pending its formal report, that everything is tied up with everything else; that pensions are actually incidental, not the whole thing; that medical research is as important as the probing of economics; that solutions cannot be hurried; and that attitudes must be remade, laws or force having no effect upon them. The published report will soon be available. If the conference is to have constructive and permanent value, this report must reflect adequately and fairly, without slanting, the deliberations of the committees, most of whose members were not employed by the federal government but represented the many and varied phases of American democratic life.

Voluntary Health Agencies Distinctly American

The American people are enthusiastic supporters of a just cause. They spend their money and they spend their time, hours upon hours of it, promoting, developing and strengthening voluntary agencies with desirable goals. "That is why," writes Dr. George F. Lull in a recent number of *The Crippled Child*, "300,000 outstanding men and women voluntarily serve on the boards and committees of 20,000 voluntary health agencies. That is why the American public subscribes an annual \$100,000,000 in gifts ranging from pennies to fortunes to permit these agencies to do their work. That is why millions of volunteers roll up their sleeves to plan and execute, and collect the money needed to execute, the hundreds of health programs directed toward health education, research in disease prevention and control and assistance to the unfortunate victims of disease."

The remarkable advances in the war against specific diseases that have been made possible by zealous workers serving their fellow Americans through voluntary organizations make an imposing contribution. These voluntary health agencies are distinctly American institutions.

Dr. Lull regards the 20,000 voluntary agencies in the United States as the world's most effective means of promoting and expressing the human impulse to help others. In describing this American phenomenon, he made this wise observation:

"Health agencies of this character are the product of a philosophy of living and a social and economic condition. They could not exist, let alone grow to their present level of service, under a socialistic or totalitarian philosophy of government."

YOUR BLUE SHIELD

Medical Interpretation of Blue Shield Contract

The preservation of the physician-patient relationship is dependent upon the confidence of the public in the voluntary plans. The voluntary plans feel that there is a possibility of this confidence being jeopardized and feel that it is their duty to safeguard this confidence by more clearly defining to the physicians, the provisions of the Blue Cross-Blue Shield contracts.

Because the plans have not made clear to the physician the provisions of the contracts, many patients feel that in many instances denial of liability by the Plans is unjustified and have frequently suggested that payment was assured by the physician at the time of consultation. In connection with solely diagnostic admissions and services in connection with conditions pre-existing the effective date of the contract, the public attitude brought about by the rejection of such cases reflects not only upon the plan, but also upon the physician.

Diagnostic Admissions

The first type of service mentioned above deals with hospital admissions involving only diagnostic procedures which do not include treatment or care by the physician for sickness, disease or injury. It is not the intent of the plans to provide benefits when the admission is a means of convenience for obtaining services without cost. If, however, the patient is acutely ill or his health is in danger, the diagnosis and treatment of such a condition would be deemed justifiable by the Plans. If the physician feels that a sickness does exist and that hospital facilities and bedside nursing service are necessary, benefits would be provided. If, on the other hand, a patient is hospitalized solely for a physical and diagnostic study and is not acutely in need of medical care, liability would be denied.

Pre-Existing Conditions

Relative to conditions pre-existing the effective date of the contract, the intent of the Blue Cross-Blue Shield Plans is to provide benefits where justified and necessary, and where the coverage was

obtained in good faith without intent to have care provided for conditions known to require hospital and medical services. The attitude of the plans is that a claim is justified where symptoms for the specific condition were not noted prior to the effective date of the contract, or where a condition in the past had obviously become arrested, but exhibited new manifestations after the coverage became effective.

The following method by which the physician may deal with the problem of pre-existing conditions has been suggested by the Blue Cross-Blue Shield Plans. The physician should question the patient as to the date on which hospital, medical and surgical coverage was obtained and should base his suggestion to the patient concerning the liability of the Plans upon the patient's personal case history. If specific symptoms were noted prior to the date on which coverage became available, the physician should point out to the patient the improbability of the services being provided for by the Plans. Although a full investigation will be made in each case and final approval or disapproval will be based upon the information submitted, the physician's opinion in this respect at the time of examination or service will tend to prepare the patient for a possible adverse decision by the Plans.

The cooperation of each Blue Shield physician is requested in continuing successful physician-patient relationships.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Allen, Risdén T., Jacksonville
Greene, Leon N., Miami
Holmes, Samuel G., Pensacola
Perlmutter, Irwin, Miami
Plotkin, Paul, Miami Beach
Read, Frances E. M., Jacksonville
Riesenbeck, Leo H., Miami
Romaine, Mason, III, Jacksonville
Sigman, Murray D., West Palm Beach
Strain, Richard E., Miami
Toporoff, Jacob, West Palm Beach
Turner, Gary E., Jacksonville
Wallace, James E., Jacksonville

STATE BOARD OF HEALTH

Mosquito Control

Mosquito control continues to receive public support in the state. This can be demonstrated by the fact that three new counties initiated mosquito projects in 1950, and the 1949 Florida Legislature passed a Mosquito Control Aid Bill.

The following counties have organized mosquito control districts: Dade, Broward, Palm Beach, Martin, St. Lucie, Indian River, Brevard, Volusia, St. Johns, Lake, Pinellas, Hillsborough, Manatee, Sarasota and Lee. In addition, the following counties are now in the process of voting in mosquito control districts: Monroe, Nassau and Bay.

The organized districts will disperse approximately \$620,000 raised through taxation in the respective counties during the 1950 season. In addition, the state has contributed approximately \$83,000 to the organized districts.

Many of the cities and county health departments carry on mosquito control work, and it is estimated that these agencies appropriate approximately \$60,000 a year for this purpose.

The mosquito aid legislation, which carried an appropriation of \$350,000, makes it possible for a county to receive assistance in the form of insecticides, materials, equipment, trucks and personnel from the State Board of Health in the amount of \$15,000 for any one county.

It can readily be seen that mosquito control is becoming big business in the state. With new insecticides and better equipment it is possible to alleviate the mosquito problem in areas at the present time which were impractical to control in the past.

Many counties along coastal Florida are reaping great benefit from mosquito control in attracting and holding summer tourists, which is adding materially to the income of the citizens of the state.

Physicians should be interested in mosquito control for several reasons. Many species of mosquitoes transmit disease, as is well known, and the role of the mosquito as a pest is of interest to everybody. It is believed that property values throughout Florida will be enhanced considerably with the more effective control of these insects. Much additional knowledge is needed on this subject, and the State Board of Health is engaged in a modest research program in this field through its Division of Entomology.

Reporting Enteric Diseases Early

For years health authorities have reported the decreasing incidence of enteric diseases and particularly of water-borne epidemics of these diseases. It is true that cases of typhoid fever, paratyphoid fever and water-borne bacillary dysentery have become so rare as to be almost extinct. This phenomenon is attributable to sanitary engineering advances in methods of handling and treating public water supplies and sewage, as well as to medical advances in the immunization of large segments of the population and to the treatment of diseases.

Sanitary engineers have long believed, however, that while great strides have been made, much remains to be done to provide all communities with safe water supplies and adequate sewerage systems. Since there are many known instances in which polluted water has been used by a community over an appreciable period of time before correction, it seems unlikely that there has been a complete absence of all forms of enteric epidemics. Actually, physicians and health officials are cognizant of the fact that considerable numbers of unreported cases of enteric disorders occur. This is no reflection upon the medical profession because in many cases these are nonspecific disorders, or, if specific, they are not on the list of reportable diseases. Thus almost every summer the State Board of Health hears rumors of epidemics of intestinal disorders, sometimes after the epidemic has ceased to exist. In many cases physicians have become accustomed to annual epidemics of mild gastroenteritis and fail to be disturbed by such occurrences. Another example of unreported epidemics is the occurrence in epidemic numbers of ear, nose and throat infections among people bathing in a particular bathing place. Skin disorders and fungus infections have been rumored to have occurred at both swimming pools and bathing beaches.

Most of these diseases are preventable if steps are taken at the right time to trace the cause and eliminate it. It is difficult, however, to trace the cause after the epidemic has disappeared. This is particularly true of water-borne epidemics. It is essential that health officers and sanitary engineers know about the epidemic while it is still occurring. It is desirable, therefore, that physicians encountering a number of concurrent cases of the same disease or disorder over a relatively short period of time call the County Health Department or write the Bureau of Preventable Diseases, State Board of Health, Jacksonville, and relate the circumstances observed.

STATE NEWS ITEMS

The presidential address of Dr. Walter C. Payne of Pensacola, which was presented at the 1950 annual convention in Hollywood, was carried in full in the September issue of *The Journal of the Medical Association of Georgia*. Dr. Payne's address was distributed to state and territorial medical associations by the Public Relations Department of the A.M.A. and has received comment and favorable commendation in several medical journals.

Dr. I. Leo Fishbein of Miami Beach attended the First International Congress of Psychiatry which was held in Paris, France on August 25.

The thirty-sixth annual meeting of the Radiological Society of America will be held in Chicago, December 10-15, according to Dr. Warren W. Furey of Chicago, president of the Society.

Headquarters for the meeting will be the Palmer House in which all scientific and technical sessions will be held. More than 60 papers as well as refresher courses feature the convention program.

Dr. Webster Merritt of Jacksonville was the principal speaker for the graduation exercises of the School of Nursing at Riverside Hospital held in September.

Dr. Mark E. Adams of Jacksonville attended the Southern Obstetric Seminar held in July at Saluda, North Carolina.

The sixth annual meeting of the Southeastern Allergy Association will be held at the Vinoy Park Hotel, St. Petersburg, on Jan. 20-21, 1951. Reservations are to be made individually with the Vinoy Park Hotel, which is on the American Plan.

If you wish to present a paper, contact the secretary immediately. A panel discussion of Allergic Chest Diseases will be under the direction of Dr. Raymond Arp. Dr. Clarence Thomas will head the panel on Rhinological Allergy.

For additional information contact the secretary, Dr. Katharine Baylis MacInnis, 1515 Bull Street, Columbia, S. C.

Dr. Carlos P. Lamar has resumed his practice in Miami following his return from Augusta, Georgia, where he gave a series of lectures at the University of Georgia School of Medicine.

Dr. Scottie J. Wilson of Ft. Lauderdale addressed the Miami Dietetic Association recently in the shelter of the Casino in Ft. Lauderdale.

Dr. Allen S. Shepard has resumed his practice in Key West following his return from New York City where he attended a course in post-graduate study.

Dr. C. Burling Roesch of Jacksonville recently addressed the active and inactive American Red Cross first aid instructors at the John Gorrie Junior High School.

Dr. Zaven Seron of Sebring was the guest speaker at a recent meeting of the local Rotary Club.

Dr. Egbert V. Anderson of Pensacola is one of Florida's delegates who will attend President Truman's midcentury White House conference on children and youth in December.

Among the Florida doctors who attended the first worldwide heart conference held in Paris, France, September 3-9, were Drs. Arthur J. Bieker, St. Petersburg, and Russell W. Ramsey, Winter Park.

The annual meeting of the Southeastern States Cancer Seminar will be held in Jacksonville, November 8-10, at the George Washington Hotel. See the commentary section of your October Journal for more detailed information on this Seminar.

Dr. Henry G. Sweany of Chicago has become the chief medical director of the state's tuberculosis sanatoriums. Dr. Sweany comes to Florida following thirty years' experience as director of research and laboratories at the Municipal Tuberculosis Sanitarium in Chicago.

WANTED: Resident physician for hotel in Miami area November 20, 1950 to May 1, 1951. Florida license necessary. Salary \$500.00 month and maintenance. Single man preferred. Write 69-42, P. O. Box 1018, Jacksonville, Fla.

Dr. Ashbel C. Williams of Jacksonville presided at the August meeting of the Florida division of the American Cancer Society which was held in Tampa.

Dr. Reuben B. Chrisman, Jr., secretary of the Dade County Medical Association has been invited to speak on Dade County Public Relations at the annual A.M.A. Public Relations Conference in Cleveland, Ohio, in early December.

Dr. Harrison G. Palmer of St. Petersburg has returned from a tour of northern states. While in Michigan, he attended the Michigan State Medical Society Convention which was held in Detroit.

President Herbert E. White of St. Augustine, chief of the medical and surgical staff of the Flagler Hospital, has moved his offices into the recently completed addition to the hospital building.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Edward R. Annis of Miami announce the birth of a daughter, Kathleen Deborah, on September 6, 1950.

Dr. and Mrs. Robert F. Farrington of Miami announce the birth of a daughter, Diana, on August 22, 1950.

Dr. and Mrs. Joseph Farrington of Jacksonville announce the birth of a daughter on July 22, 1950.

Dr. and Mrs. Arthur L. Hardie, Jr., of Jacksonville announce the birth of a son on September 3, 1950.

Deaths — Members

Norris, Samuel R., Jacksonville Sept. 21, 1950

A. M. A. Public Relations Conference

December 3-4, 1950

Cleveland, Ohio

FOR RENT OR LEASE: Modern building, equipped as 10-bed hospital for surgical, obstetrical and general practice. May be operated as office only. Located in south Georgia. For full information, write Samuel C. Atkinson, M.D., 320 East Twentieth Street, New York, N. Y.

COMPONENT SOCIETY NOTES

Columbia

The October meeting of the Columbia County Medical Society was held in Lake City Monday, October 2, with Dr. Thomas H. Bates presiding. A motion picture of the A.M.A. 1950 convention recently held in San Francisco was shown to the members of the society by W. Harold Parham, supervisor of the F.M.A. Bureau of Public Relations. Guests at the meeting were doctors of the staff of the Veterans Administration Hospital in Lake City.

Dade

The Dade County Medical Association held its regular monthly meeting on October 3 at the Miami Woman's Club. The scientific program was headed by Dr. Joseph W. Scott, who discussed "The Early Diagnosis and Treatment of Carcinoma of the Cervix and Body of the Uterus."

Duval

The regular monthly meeting of the Duval County Medical Society was held in the Sellers Auditorium Tuesday, October 3. Guest speaker was Dr. Hal McC. Davison, Atlanta, who presented a paper on "Psychosomatics in Allergy."

The scientific program was preceded by the showing of a motion picture of the 1950 A.M.A. annual convention held in San Francisco in June. The film was made available to the society through the F.M.A. Bureau of Public Relations and was shown by W. Harold Parham, Bureau supervisor.

Marion

At the September meeting of the Marion County of the Marion County Medical Society, the guest speaker was Dr. Charles E. Tribble, mayor of DeLand and past-president of the Volusia County Medical Society. Dr. Tribble presented a paper on "The Doctor and His Community."

The following members were present: Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, Bertrand F. Drake, Henry L. Harrell, John D. Lindner, Carl S. Lytle, William J. McGovern, Robbins Nettles and Thos. H. Wallis, Ocala; Matthew Arnow and Clifford E. Vinson, Williston; and Herbert M. Webb, Jr., Wildwood.

Pinellas

The first fall meeting of the Pinellas County Medical Society was held at the Detroit Hotel, St. Petersburg, on September 11, with Dr. Albert R. Frederick presiding. On the scientific program, Dr. Paul S. Wallace gave an illustrated lecture on "Fibro-elastic Diathesis of Mesenchymal Tissue."

Dr. Whitman C. McConnell, secretary, presented proposed amendments to the By-Laws as approved by the executive committee.

OBITUARIES

Warren Edward Anderson

Dr. Warren E. Anderson of Pensacola died unexpectedly on Aug. 21, 1950 at his Fisherville home near Warrington. He was 58 years of age.

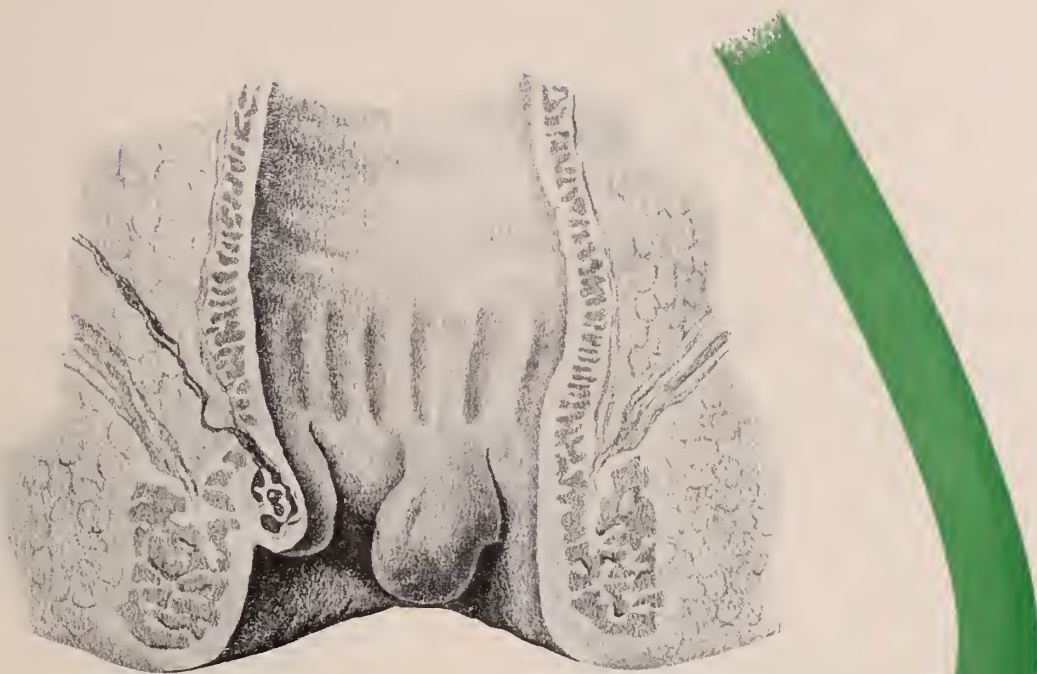
The son of the late Dr. Warren Anderson and Catherine Hargis Anderson of Pensacola, Dr. Anderson was born there in 1892. He received his medical education at the Emory University School of Medicine in Atlanta, Ga. Upon graduation in 1916, he returned to his birthplace to practice medicine.

For seventeen years a general practitioner and surgeon in Pensacola, Dr. Anderson was a past president of the Sacred Heart Hospital staff and was one of the four founders of the Pensacola Maternity Hospital.

Dr. Anderson was a veteran of World War I. Interested in politics, he was elected in 1948 to the Democratic National Convention, running as a state-at-large candidate.

He was a member of the Escambia County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are his widow, Mrs. Sophie Anderson of Fisherville; seven brothers, Robert H., Thomas and Frederick of Miami; Roulhac, William D. and Richard S. of New York, and J. Berwick of Green Cove Springs; and two sisters, the Misses Modeste and Catherine Anderson of Pensacola.



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Biolac is available in 13 fluid ounce tins.

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William Frederick Bay

Dr. William F. Bay of Bradenton died on April 4, 1950 after suffering a cerebral hemorrhage. He was 77 years of age.

Born at Marietta, Ohio, on May 14, 1873, Dr. Bay received his medical degree from Ohio Medical University in Columbus in 1894. He was licensed to practice medicine in Florida in 1938 and the following year became a member of the Florida Medical Association. In 1940 and 1941 he did postgraduate work at the University of Michigan.

Dr. Bay practiced in Columbus, Ohio, before coming to Florida twelve years ago. He served in World War I and World War II.

In addition to membership in the Florida Medical Association, Dr. Bay held membership in the Manatee County Medical Society and the American Medical Association.

He is survived by his widow, Mrs. Mabel Bay, now residing in Bradenton.

Wilson McArthur Lancaster

Dr. Wilson McArthur Lancaster of Orlando died at the Osceola Hospital in Kissimmee on Aug. 15, 1950. He was 66 years of age.

Dr. Lancaster was born in Ontario, Canada, in 1885. He received his medical degree in 1909 from the University of Western Ontario Faculty of Medicine at London in his native province.

He then practiced medicine in Wahpeton, N. D., until he moved to Kissimmee in 1932. He established the Osceola Hospital there, which he operated until 1947. At that time he moved to Winter Park and became associated with his daughter, Dr. Avaline Lancaster Cannon, in the practice of medicine, with offices in Orlando.

This well known Osceola and Orange County physician and surgeon was a member of the Orange County Medical Society, the Florida Medical Association and the American Medical Association. He was a communicant of St. John's Episcopal Church in Kissimmee.

Surviving are his widow, Mrs. Minnie E. Lancaster; two sons, Donald B. Lancaster of Pine Castle and Robert M. Lancaster of Kissimmee; one daughter, Dr. Cannon; one brother, Dr. Blake Lancaster of Bradenton; one sister, Mrs. F. A. Staples of Toronto, Canada; and six grandchildren.



From where I sit by Joe Marsh

Ought To "Polish Up" Her Traffic Manners!

Spent most of yesterday over at the Court House. "Tiny" Fields, the biggest and fastest-talking of our three policemen, was holding forth about his traffic troubles.

"Women drive just as good as men do," Tiny said, "and just as bad. For instance—a girl in a convertible today. She started a three-block tie-up all by herself.

"She's creeping down Main Street—left hand stuck out and sort of waving around. Never turns right or left, never stops. But, of course, everyone behind her thinks she's signaling about something. Nobody dares to pass. When I stop her and ask what's up, she smiles sweetly and explains that she's drying her nail polish!"

From where I sit, that girl's typical of certain folks who are so wrapped up in themselves, they never notice they're not being fair to others. Our neighbor has a *right* to drive in safety—just as he has a right to enjoy a glass of beer. Let's all respect the other fellow's rights.

Joe Marsh

simplify the
mother's
problem

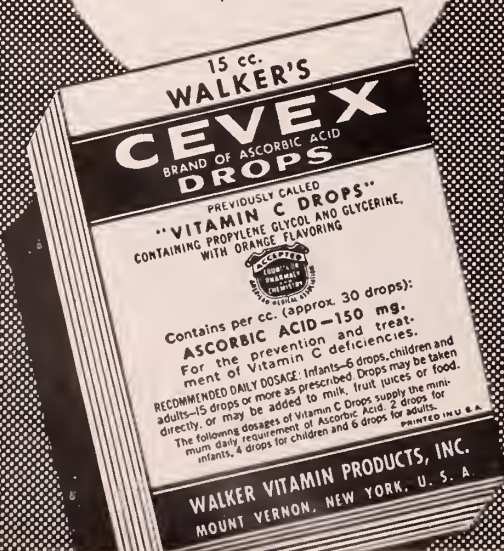
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What Every Doctor Should Know

In one of his convention addresses, Dr. Elmer Henderson, president of the American Medical Association brought before the doctors the startling fact that the Woman's Auxiliary had grown in size to over 50,000 members from what he recalled as a skeleton organization ten years ago. "There must be a reason for that," he said.

There is a reason. In the days of skeletal structure women were doing what I am doing now, urging doctors and their wives to recognize the value of membership in this organization so that when we have a real objective and something to work for we shall have something with which to work.

Ten years ago the doctors' attitude was different. This was because they have always had a strong organizational structure manned by able, conscientious doctors who guided the affairs medical. But, when a calamity threatened there was immediate mobilization of individuals from every county in the country. With the doctors who rallied to medical defense came their wives. It's as simple as that.

Yet, we have much work to do for as Mrs. Leo Shaefer, National Organization Chairman, said, "The American Medical Association reports an active membership of 144,500 doctors. Compare that to 50,000 doctors' wives."

Is it possible that over 90,000 doctors' wives don't know about the Auxiliary? I can't believe that that many could know of our organization and the work it has done for the doctors of America and be willing not to share in its future. Is it

possible that even half that number are disinterested in the future of medicine? It is more likely that we are remote to many because their husbands haven't shown the way and we haven't yet reached them.

Imagine the tremendous influence of 289,000 people actively opposing socialized medicine, socialism, and communism. Each in his own sphere of influence educating his friends and daily contacts would start up a chain reaction which couldn't be beat.

How can this be accomplished? Through the doctor. If his wife stands by his side to be counted the active A.M.A. membership number is doubled in effectiveness. This every doctor should know.

Mrs. C. Robert DeArmas,
President-elect.

BOOKS RECEIVED

PHYSICIAN'S HANDBOOK. By Marcus A. Krupp, M.D., Norman J. Sweet, M.D., Ernest Jawetz, Ph.D., M.D., and Charles D. Armstrong, M.D. Ed. 6. Price, \$2.50. Pp. 380. Palo Alto, Calif.: University Medical Publishers, 1950.

This handy pocket reference for both student and physician offers a readily available source of factual data, laboratory procedures, and clinical aids repeatedly used in all branches of medicine. In this sixth edition all sections have been completely revised and often expanded; there are 86 more pages than in the previous edition. Further emphasis has been given to basic principles which aid in understanding the material presented. Among the new sections are those dealing with electrocardiography, electroencephalography, radioisotopes, and simplified laboratory procedures.

The original authors and publishers, Dr. John Warkentin and Dr. Jack Lange, finding it impossible to maintain adequate revisions, met this problem with the present edition by enlisting the aid of new authors who restrict their writings to those portions of the Handbook with which they are thoroughly familiar.

NEW AND NONOFFICIAL REMEDIES, 1950. Issued Under the direction and Supervision of The Council of Pharmacy and Chemistry, American Medical Association. Price, \$3.00. Pp. 800. Philadelphia: J. B. Lippincott Company, 1950.

This annual publication was made available in August this year. In it are listed and described articles which the Council on Pharmacy and Chemistry of the American Medical Association found acceptable up to Jan. 1, 1950. The book provides statements on actions, uses, dosage, tests and standard of the preparations and articles. It also contains certain official preparations and other articles including drug substances for manufacturing use for which there are not official standards, which the Council is of the opinion should be included for the information of the medical profession.



PHYSICIANS of the South have an urgent call to St. Louis for the annual meeting of the Southern Medical Association, Monday, Tuesday, Wednesday and Thursday, November 13-16. Medical meetings are essential in times of war as well as in times of peace. In the light of the world situation today this meeting of the Southern Medical Association may be the last complete general medical meeting to be held for some time to come. With this thought in mind, it is very important that all physicians take advantage of this opportunity to bring themselves up to date on the latest developments in the profession.

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1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. 209: 33-41 (Jan.) 1945.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	
B-Northeast	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	
Florida Specialty Societies			
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	Hollywood, Apr. 22, '51
Anesthesiologists, Soc. of	Ralph S. Sappenfield, Miami	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Acad. Gen. Prac.	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Term. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Ophthalmological Society	Nelson A. Murray, Jacksonville	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Otolologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Otiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" "
Orological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 11, '50
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	Hollywood, Nov. 19-22, '50
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, December, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 3, '50
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, Nov 26-28, '50
Medical Postgraduate Course	Turner C. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
Public Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Cleveland, Dec. 5-8, '50
Southern Medical Association	Hamilton W. McKay, Charlotte, N. C.	Mr. C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
E. Hospital Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	St. Petersburg, April 4-6, '51
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg, Jan. 20-21, '51
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	E. L. McCafferty, Jr., Mobile, Ala.	

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					Total	Paid	
A	Bay	Daniel M. Adams, Jr., M.D. Panama City Hospital Panama City	Jack Corbitt, M.D. Box 961 Panama City		17	16	A-1-52 Arthur J. Butt, Jr., M.D. Pensacola
	Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	69	
	Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
	Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	17	
	Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	18	17	
	Leon Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	48	100%	
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	Taylor *Dixie-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Poley	Last Friday 8:00 P.M.	3	100%	215
B	Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 825 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	42	41	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
	Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	249	239	
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	Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	60	55	601
C	Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	153	148	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Millard P. Quillman, M.D. Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	20	100%	
	Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	100%	
	Pinellas	Albert R. Frederick, M.D. 116 4th Ave., N.E. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	169	167	
	Sarasota	Falmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	38	100%	
	DeSoto-Hardee- Highlands- Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	24	C-6-52 Leldon W. Martin, M.D. Sebring
	Lee-Charlotte- Collier-Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	25	24	
	Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	84	80	
	Indian River	Melton D. Council, M.D. Box 1096 Vero Beach	William J. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	
	Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peck, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	99	98	D-7-52 Adrian M. Sample, M.D. Fort Pierce
D	St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	15	100%	
	Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	76	100%	
	Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	551	504	
	Monroe	Herman K. Moore, M.D. 600 Elizabeth St. Key West	Allen S. Shepard, M.D. 403 Caroline St. Key West	2nd Thursday 8:00 P.M.	11	10	759

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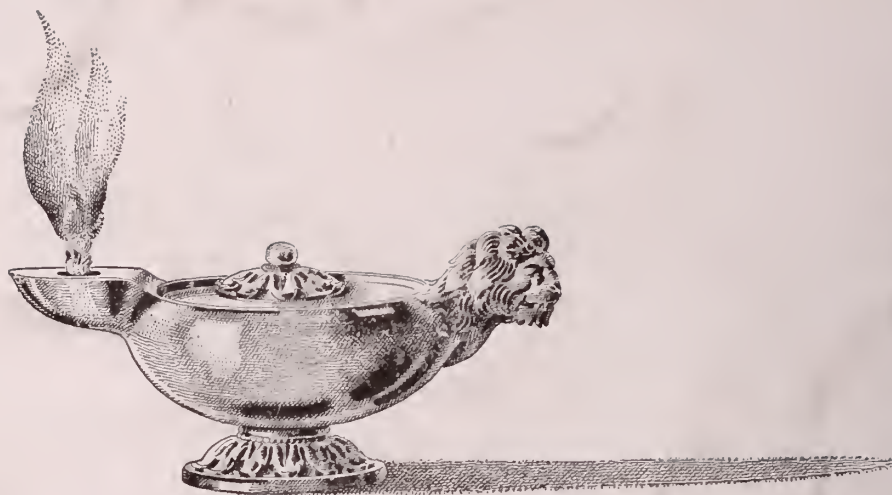


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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

DECEMBER, 1950

No. 6

IN THIS ISSUE

Spontaneous Internal Biliary Fistulas

Donald W. Smith, Maurice M. Greenfield
and Martin G. Gould



Blindness in Children

Nathan S. Rubin



Carcinoma — Head and Neck

J. Brown Farrior — Richard A. Bagby



Cataract Operation

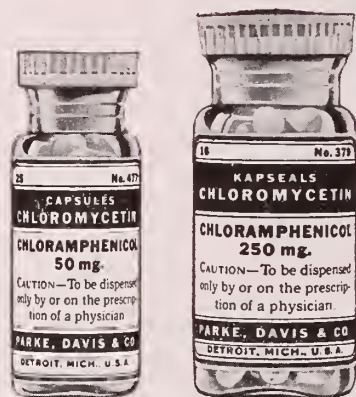
Charles W. Boyd



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2. Recinos, Jr., A.; Ross, S.; Olshaker, B., and Twible, E.: New England J. Med. 241:733, 1949.
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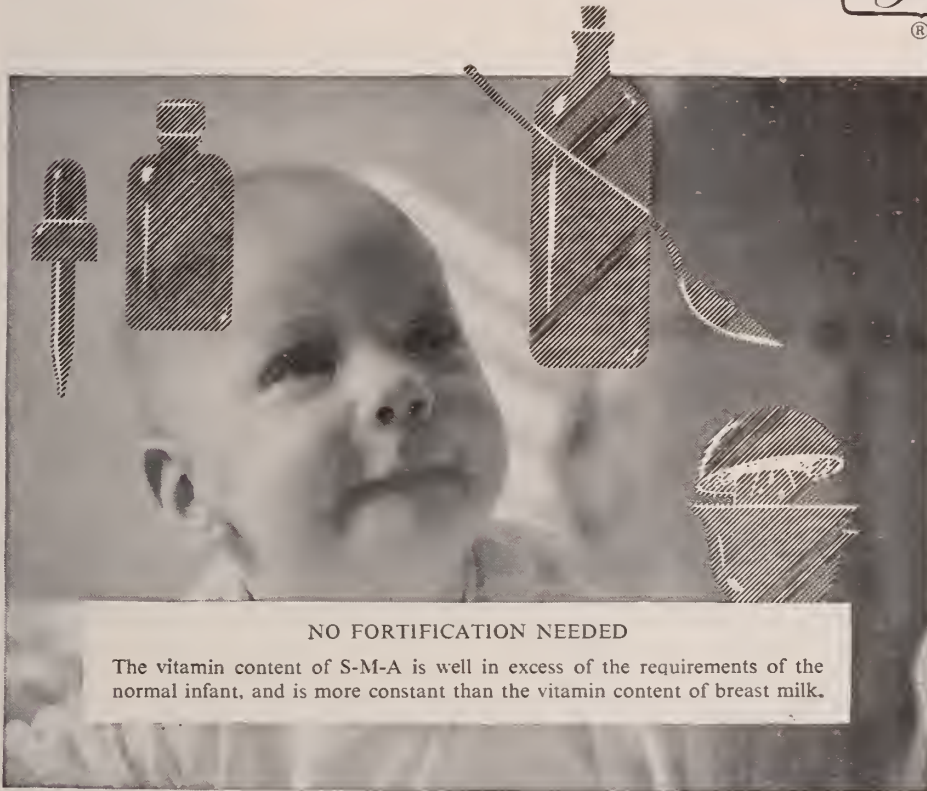
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resistant to "...all available antibiotics and
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P.H.: Pyelonephritis of 1½ years' duration following uretero-cutaneous implants (mixed infection); previous therapy with all available antibiotics and chemotherapeutic agents without response.

Lab. data: Urinary cultures positive for *P. vulgaris*, *E. coli*, *Staph. albus* and enterococci.

Therapy: Terramycin 2 Gm. daily for five days; orally in divided doses q. 6 h.

Result: Urine cultures negative except for *P. vulgaris* by 2nd day of treatment. Response described as "good".

Case report abstracted from: King, E. Q. et al.: J.A.M.A. 143:1 (May 6) 1950.

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acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to *E. coli*, *A. aerogenes*, *Staphylococcus albus* or *aureus*, and other Terramycin-sensitive organisms; acute brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.

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Dosage: On the basis of findings obtained at over 150 leading medical research centers, 2 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.

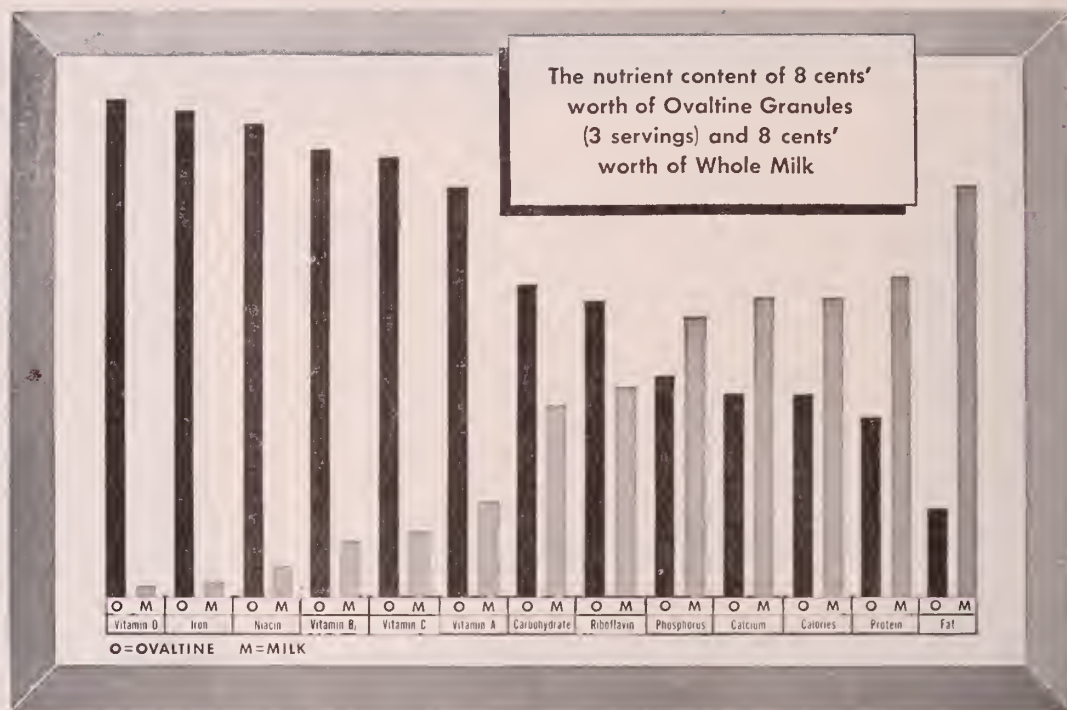
Supplied: 250 mg. capsules, bottles of 16 and 100;
100 mg. capsules, bottles of 25 and 100;
50 mg. capsules, bottles of 25 and 100.

1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J.A.M.A. 143:1 (May 6) 1950.
2. Merrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.

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Carbohydrate	29 Gm.	19 Gm.
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** 8 cents' worth of milk

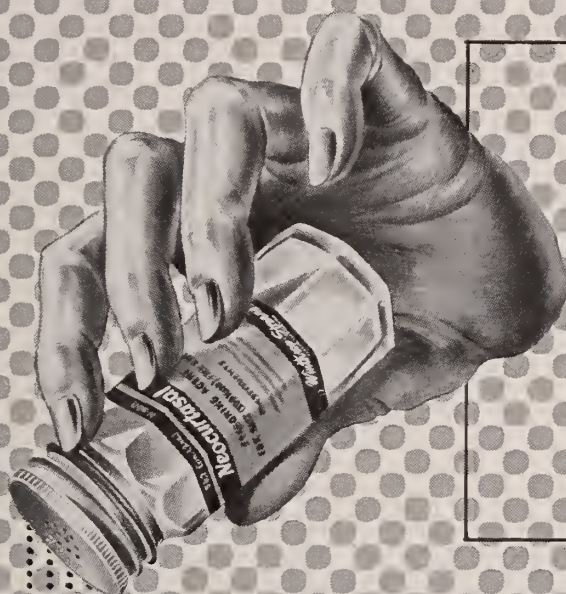
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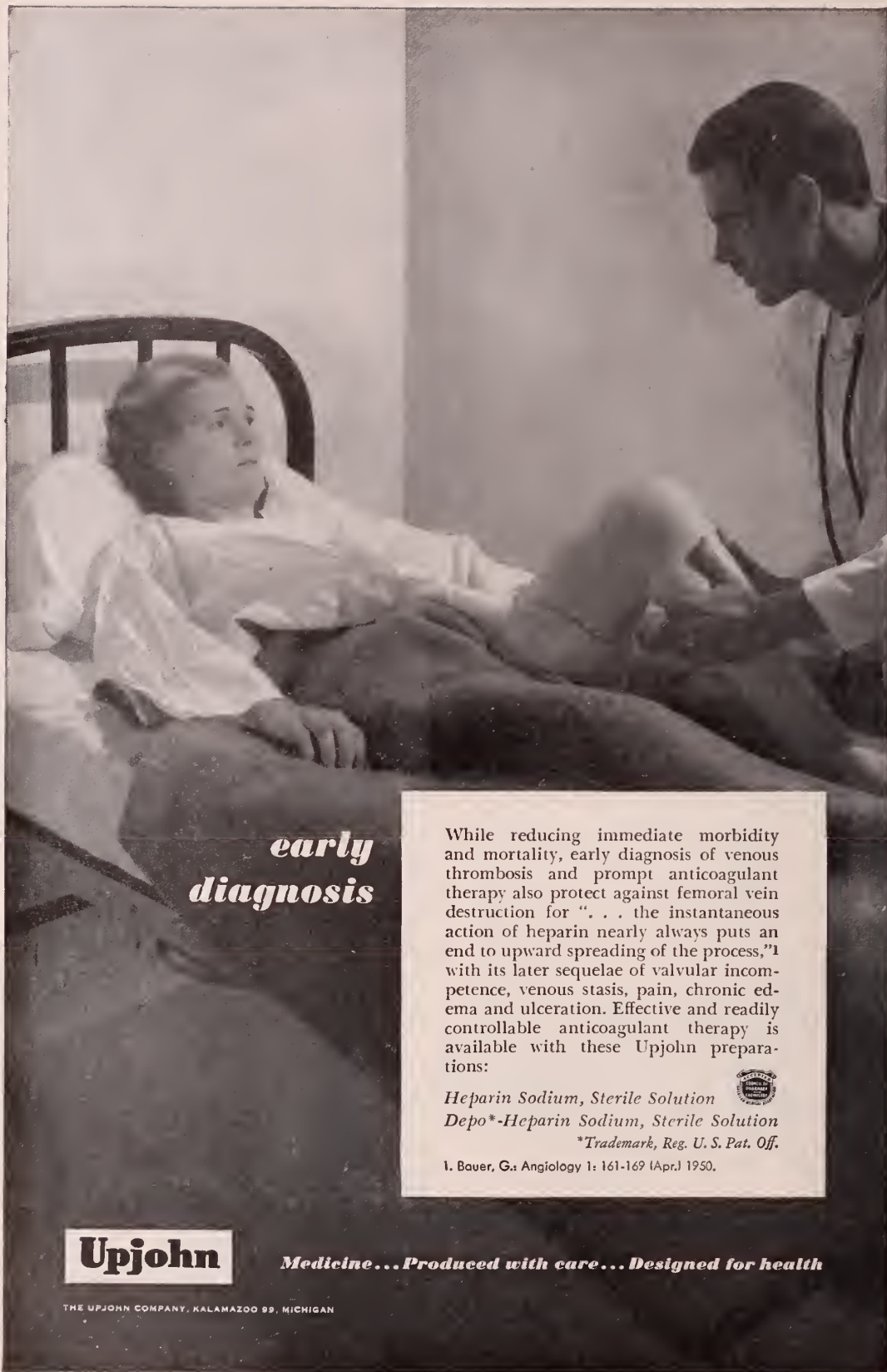
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1. Bauer, G.: *Angiology* 1: 161-169 (Apr.) 1950.

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1. Nesbit, R. M., and Glickman, S. I.: J. Michigan State M. Soc. 46:664, 1947.

2. Dodson, A. I.: West Virginia M.J. 45:11, 1949.

3. Seneca, H.; Henderson, E., and Harvey, M.: J. Urol. 61:1105, 1949.

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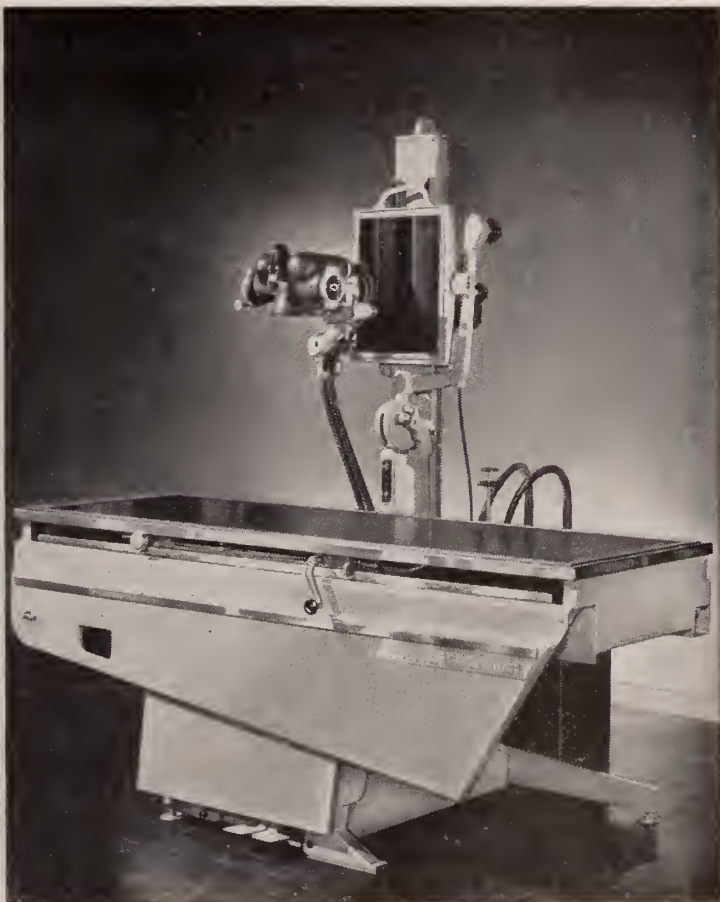
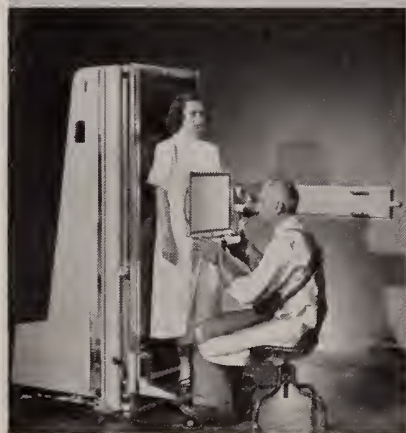
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REFERENCES:

1. Gordon, E. S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947.
2. Manchester, T. C.: Food Research, 7:394, 1942.
3. McLester, J. S.: Nutrition and Diet, Saunders, 4th ed., 1944.
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5. Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, 7th ed., 1946.



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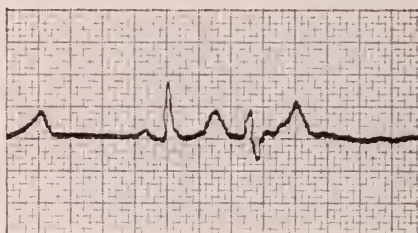
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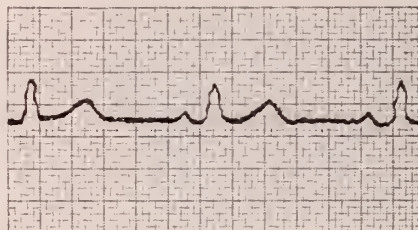
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Control tracing:
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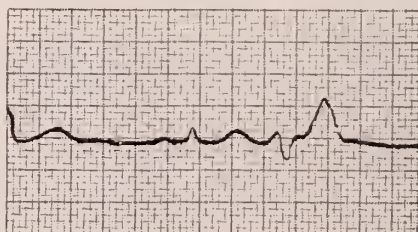
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No ventricular premature
contractions present.



Lead II.
Tracing 7½ hours
later shows
persistent effect.



Lead II.
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shows return of
ventricular premature
contractions.



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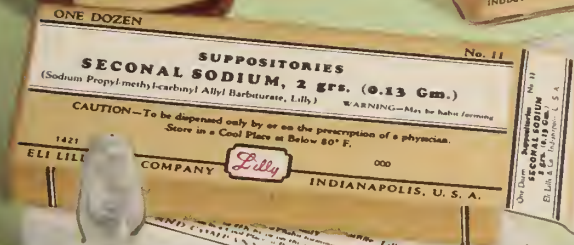
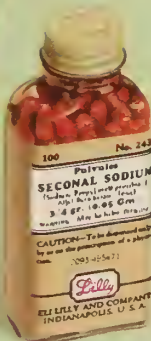
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The Diagnosis of Spontaneous Internal Biliary Fistulas and The Complication, Gallstone Ileus

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Spontaneous internal biliary fistulas have long been recognized, but prior to 1915 when Hunt and Herbst¹ made the first roentgenologic diagnosis, they were recognized only at the time of operation or at postmortem examination. Even today the correct clinical diagnosis is frequently missed. This lack of recognition arises from insufficient attention to roentgenologic signs, which, when present, are almost pathognomonic.

It is our purpose to stress the importance of recognizing these fistulas, when present, in cases of acute intestinal obstruction. For illustration we shall present 2 cases taken from our records at the Jackson Memorial Hospital.

The incidence and relative frequency of these fistulas vary markedly in the series reported. In 10,866 autopsies, Roth, Schroeder and Schloth² reported 43 internal biliary fistulas. At the University of Minnesota Hospital,³ in 19,474 autopsies, only 24 were noted. In the combined series the incidence is 0.22 per cent.

The incidence of these fistulas encountered in operations on the biliary tree is higher than would be expected. Bernhard,⁴ in 6,263 operations on the biliary tract, found 109 fistulas, an incidence of 1.8 per cent. Puestow⁵ in 500 similar operations reported 16, or an incidence of 3.2 per cent.

The principal types of spontaneous internal biliary fistulas are those in which some portion of the biliary tree, usually the gallbladder or the common bile duct, forms a direct communication into the duodenum, colon or stomach. Table 1 shows the four main types of fistulas with their relative frequency.

Recorded in the literature are many rare types of internal biliary fistulas. In 1909, Robson⁶ reported accumulated cases in which these fistulas involved the pregnant uterus, an ovarian cyst, the urinary bladder, the pelvis of the kidney, the pleura and the lungs. They, however, constituted less than 1 per cent of these fistulas.

The etiology of spontaneous internal biliary fistulas is well established, and it is generally agreed that cholelithiasis is the main factor in their formation. Approximately 90 per cent of all cases are associated with gallstones. A gallstone impeded in its passage through the cystic or common bile ducts or by pressure necrosis in an inflamed gallbladder may ulcerate through the wall of the ducts of the gallbladder into an adherent viscus, and so form a fistula. Approximately 80 per cent of these fistulas are cholecystoenteric in type. Choledchoenteric fistulas due to stones are rare.

Penetrating duodenal ulcers account for some 6 per cent of fistulas. In these cases, a choledcho-duodenal type of fistula is more likely to develop owing to the close anatomic relationship of the common bile duct to the posterior wall of the first part of the duodenum. Garland and Brown⁷ emphasized that the penetrating duodenal ulcer is

Table 1.—Incidence of Spontaneous Biliary Fistulas, as Compiled from 936 Reported Cases (Surgical, Radiologic or Autopsy Diagnosis)

Type	Per Cent
Cholecystoduodenal	59
Cholecystocolic	23
Choledchooduodenal	10
Cholecystogastric	8

the commonest cause of the choledochoduodenal type of fistula. A peptic ulcer on the superolateral or anterior wall of the duodenum, however, may involve the gallbladder in a rare type of cholecystoduodenal fistula.

The remaining 4 per cent of fistulas are due to carcinoma of the gallbladder, bile ducts, stomach and head of the pancreas. These fistulas are usually complex and often multiple.

There are no specific symptoms of a spontaneous internal biliary fistula. The development of a fistula may be heralded by a sudden accentuation of the previous symptoms of the underlying pathologic condition, usually cholelithiasis with cholecystitis. This is due to a superimposed cholangitis. Occasionally, however, there may be no symptoms referable to the biliary tree. The patient may be admitted with a typical clinical picture of acute obstruction of the small bowel. A history of gallbladder disease in the past or of recent symptoms of this condition may be elicited. Spontaneous internal biliary fistula should be considered in the differential diagnosis of intestinal obstruction as it may well lead to a preoperative diagnosis of gallstone ileus.

The following report of 2 illustrative cases emphasizes the importance of the correct interpretation of scout films of the abdomen in cases of acute intestinal obstruction.

Report of Cases

Case 1.—G. R., a 73 year old white woman, was admitted to Jackson Memorial Hospital at night on Dec. 15, 1948 complaining of pain in the upper portion of the abdomen, nausea and vomiting of three days' duration. There was a history of cholelithiasis, which was verified by roentgen examination three months previously (fig. 1). She had had two attacks of what appeared to be cholecystitis within the last four months. These subsided spontaneously.

Upon admission, her temperature, pulse and respiration were normal. There was slight abdominal distention but no tenderness. The liver was not enlarged. Peristaltic rushes were audible. A roentgen examination of the abdomen was made, and a dilated small bowel was noted. A diagnosis of obstruction of the small intestine was made. As there were no signs of strangulation, operation was deferred. A Harris tube was passed into the stomach, and parenteral fluids were administered.

On the following morning, when the roentgenogram of the abdomen was reviewed by one of us (M.M.G.), it was noted that in addition to distention of the small bowel, a large gallstone was present at the lower end of the distended loop of bowel. Gas was also visualized within the common bile duct, gallbladder and smaller hepatic ducts. A repeated roentgen examination of the abdomen, several hours later, revealed essentially the same findings, except that the gallstone had moved and could now be seen at the left side of the abdomen (fig. 2). A laparotomy was performed, and an obstructing gallstone was removed from a proximal loop of ileum. The gallbladder was bound by a mass of adhesions to the duodenum, which was thought to represent a cholecystoduodenal fistula.

This was not disturbed. Recovery was uneventful and without evidence of cholangitis.

This case illustrates how a gallstone within the gallbladder can ulcerate through into the duodenum and form a cholecystoduodenal fistula. It also emphasizes the importance of a careful study for air shadows in the region of the gallbladder and the recognition of migration of gallstones in obstruction of the small bowel. No time should be lost in preparing these patients for surgery as the impacted stone may damage or even perforate the intestines. This complication is another reason for routine cholecystectomy in cholelithiasis.

Case 2.—H. M., a 75 year old white woman, was admitted to the Jackson Memorial Hospital on March 14, 1944 with abdominal pain and distention, tenderness and borborygmus. She had no chills, fever or other evidence of inflammatory reaction. There was a history of chronic disease of the gallbladder with periodic attacks of gallstone colic. Roentgen examination revealed evidence of obstruction of the small bowel, and she was operated upon. A gallstone the size of a large walnut was removed from the ileum. The gallbladder was not explored. Recovery was uneventful.

The preoperative roentgen examination of the abdomen showed distention of the small intestine typical of obstruction (fig. 3). There was also the characteristic finger-like pattern of air within the common bile duct, indicating the presence of a spontaneous internal biliary fistula. In this case the correct diagnosis of gallstone ileus could have been made preoperatively after careful examination of the roentgenograms.



Fig. 1. Case 1. Large opaque gallstone demonstrated at time of cholecystogram prior to development of biliary fistula.



Fig. 2. Case 1. Roentgenogram of the abdomen twelve hours after admission. The obstructing gallstone is seen at the left side of the abdomen. Dilated small intestine is demonstrated proximal to the stone. The upper arrow shows air outlining the gallbladder.

Discussion

The preoperative diagnosis of spontaneous internal biliary fistula can be established only by means of roentgenologic study. The role of scout films of the abdomen is well appreciated by surgeons in the diagnosis of surgical diseases of the abdomen. It is still surprising, however, to find occasional cases in which, in the presence of obstructive signs and symptoms, the patient is not referred for roentgen examination. In many cases in which roentgen evidence of obstruction is present, the signs of a biliary fistula are also present but not recognized by the one reviewing the roentgenogram.

The roentgen diagnosis of spontaneous internal biliary fistulas is based upon: (1) the demonstration of gas in the gallbladder, biliary tree or both; or (2) contrast barium in the gallbladder, biliary tree or both.

Careful attention to technic is required in obtaining diagnostic roentgenograms of the abdomen, and frequently smaller films over the gallbladder region are required. Borman and Rigler³ emphasized this point in their excellent article on this



Fig. 3. Case 2. Roentgenogram of the abdomen showing dilated loops of small intestine. The characteristic finger-like pattern of air within the common bile duct can be clearly seen.

subject. Meticulous examination of the roentgenogram will frequently show fine linear air shadows in the region of the liver, corresponding to the biliary system. An extracolonic small or large pocket of gas should be looked for within the gallbladder region. Gas within the common bile duct is usually identified to the right of the lower dorsolumbar zone as a finger-like, longitudinal, radio-lucent shadow.

If distention of the small bowel is present, then the upper and lower zones of the small bowel loop should be examined for a solitary gallstone. Often just the calcific periphery of a gallstone can be identified. When no clinical or roentgen signs of intestinal obstruction are present, and when gas is identified in the gallbladder or the biliary tree, a small amount of thin barium may be given orally under fluoroscopic control. The reflux of barium from the duodenum into either the gallbladder or common bile duct is then clearly demonstrated in the case of cholecystoduodenal or choledochoduodenal fistulas. If the barium does not pass into the gas-outlined biliary tree, then it is likely that a barium enema study may show a cholecystocolic fistula. Barium studies are not academic in nature but of real value in establishing a complete diagnosis.

It is not the purpose of this paper to discuss in detail the treatment of these fistulas. Those due to gallstones, duodenal ulcers and neoplasms require different management, as emphasized by Hicken and Coray.⁸ While the gallstone ileus must be treated promptly, the associated fistula may be left undisturbed as spontaneous closure usually occurs.

Summary

Two cases of gallstone ileus with concomitant spontaneous internal biliary fistula are reported.

The etiology, incidence and types of spontaneous internal biliary fistulas are discussed.

The importance of recognizing air within the gallbladder or biliary system is stressed, as this finding in conjunction with obstruction of the

small bowel is pathognomonic of gallstone ileus. A radiopaque obstructing gallstone may or may not be visualized.

Barium studies in cases of spontaneous internal biliary fistula are also mentioned.

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Medical Aspects of Blindness in Children

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PENSACOLA

Medical Aspects of Blindness in Children is a subject hardly to be encompassed within the brief time permitted to me. It is my intention, therefore, to engage your consideration of particular causes of blindness that are prenatal in origin, with emphasis, where possible, on means of prevention. This last may seem surprising, but I believe you will be gratified to discover that you physicians in general practice, in obstetrics, and in pediatrics, can perform a vital role in the conservation of the vision of children.

It may disturb his ego¹ to remind that, as regards the eyes, man is but a modified fish. In the development of vision, he has compressed into a short period countless stages of evolution which have brought vision to its present advanced state in the human species, and also made the eye so vulnerable to developmental defects. Six months before birth, the eyes of the fetus move haphazardly and independently beneath their sealed lids, and development continues even into the adolescent years. During this period, the visual system is

subject to change and to damage, and blindness may occur at any time from the prenatal period through the adolescent years. In the statistics to be presented, blindness occurred in over one half of the patients before birth, and 80 per cent were blind before 5 years of age, indicating a long life of blindness with many more problems for the individual and for society.

Blindness is a relative term of several meanings. For this presentation, children are determined as blind from the point of view of education, when they have unimprovable vision in the better eye of less than 20/200 (6/6). Limitation of the field of vision will also classify the child as blind when the degree of disability is severe.

Estimates of the incidence of blindness in children may vary because of the understandable unreliability of determining always accurately the extent of the visual handicap. At the end of the 1947-1948 school year,² 5,500 children were in schools and day classes for the blind in the United States, or approximately 1 in 5,000 of the entire school enrolment. At the present time, about 850 new pupils are entering braille classes each year.

¹Read before the Florida Medical Association, Seventy-Sixth Annual Meeting, Hollywood, April 25, 1950.

The principal causes of blindness in 3,905 of these are:

Infectious diseases	16.8 per cent
Injuries	7.6 per cent
Prenatal origin	61.0 per cent
Other causes	14.6 per cent

These figures are from the 1947-1948 report of the Committee on Statistics of the Blind (table 1) and do not include the infants and preschool age children not yet enrolled in these schools. These are tragic figures that should be a matter of grave concern to you. They justify presentation to a general meeting of what would appear to be a subject of interest mainly to ophthalmologists. Yet, as you will soon discover, a vital contribution to sight conservation can be made by you.

Infectious Diseases

Foremost in the prevention of blindness in children is the eradication of the infectious diseases which formerly have taken so large a toll of eyes. The incidence of ophthalmia neonatorum has been reduced to 7.5 per cent, compared to 28 per cent in 1906 when the campaign against this disease was inaugurated. This decrease is due to better prenatal care as well as to the obligatory use of 1 per cent silver nitrate. Social hygiene legislation, which makes premarital (and in some states, antepartum) blood tests mandatory has reduced blindness from syphilis to 3.2 per cent. Trachoma, once a serious cause of blindness, is practically nonexistent because of better hygiene and the introduction of chemotherapy, particularly the sulfonamide drugs.

Injuries

Prevention of the 7.6 per cent of blindness that is due to injuries means wider and more effective safety education of parents and children in regard to the hazards in play or sport, of sharp or pointed objects, of blows or falls, of explosives. It also means support and enforcement of legislation regulating the use of fireworks and air rifles. In addition, it means stressing the importance of prompt care in the event of penetrating injury to an eye, to avoid blindness in the uninjured eye from sympathetic ophthalmia.

Congenital Defects

The waning of these causes of blindness in children brings into greater prominence new problems: the high incidence of cataracts and other congenital defects in the offspring, the increasing

Table 1. — Causes of Blindness Among Pupils in Schools and Day Classes For the Blind in the United States — School Year 1947-48*

Etiology	Per Cent of Total Pupils Enrolled
Infectious diseases	16.8
Ophthalmia neonatorum	7.5
Syphilis	3.2
Meningitis	1.3
Measles	0.7
Tuberculosis	0.5
Septicemia	0.5
Other and not specified	3.1
Injuries	7.6
Play or sport	4.8
Birth injuries	1.1
Traffic and transportation	0.5
Other and not specified	1.2
Poisonings	0.2
Tumors	3.8
General diseases	1.2
Prenatal origin	61.0
Hereditary (established or presumed)	15.7
Causes not specified	45.3
Etiology undetermined or not specified	9.4
Total—All Causes	100.0

*Based on 3,905 eye examination records of pupils in 39 residential schools and 12 city school systems in 35 states and the District of Columbia.

occurrence of retrolental fibroplasia, and the frequency of prenatal infection of the eyes of human infants by *Toxoplasma*.

Blindness involving the crystalline lens accounts for 18 per cent of the total in this group, according to United States statistics. In neighboring Alabama,³ congenital cataracts account for 53 of the 268 patients at the State Institute for the Blind, or 19.4 per cent. These are seen as congenital or developmental cataracts which are prenatal, sometimes hereditary, and sometimes caused by injury or disease in the fetus or in the mother.¹² Only in exceptional cases are congenital cataracts discovered immediately after birth. Because the pupils of the newborn are small, and because he keeps his eyes closed so much, they are not noticed until the child is weeks or even months old. This delay in discovery can become tragic because delay in remedial treatment leaves an eye with the retina and macular area undeveloped physiologically. When lens opacities are large enough to obstruct the rays of light until after the fourth year of life, the best function obtainable after their removal will not be within the range of useful vision. The retina at this age cannot entirely overcome the neglected development that came from lack of use. In the Alabama series 34 had had inadequate surgery, and 13 had had no surgery. The operation of needling, with irrigation of the anterior chamber, should be done in one eye after

the patient reaches the age of 6 months in order to prevent nystagmus. Surgery in the second eye may be postponed until the eye is larger, with a deeper anterior chamber, but not after the age of 3. When adequate surgery is done early enough in an eye which has no other abnormality, and which has been provided with a spectacle lens, the retina and macular function will develop so that good visual acuity can be obtained. In these cataracts, early recognition and early attention are mandatory. Until, and if ever, man learns how to manipulate genes and chromosomes, there is nothing that can be done to prevent the cataract of hereditary origin.

It is during the early months of intrauterine life that the eye is most liable to permanent damage through the influence of coincident infections in the mother.^{4b} Such diseases, especially German measles or other virus infections, or metabolic disturbances, may be so mild that the mother suffers slight inconvenience and attaches no importance to their presence. The congenital defects in the lens due to metabolic disturbances, as from calcium deficiency or avitaminosis during pregnancy or early in the infant's life, are readily within your province to prevent by adequate diet. So also can you prevent the congenital cataract so frequently associated with rubella (German measles).

Ever since Dr. N. McAlester Gregg⁵ of Australia noticed in 1942 the relationship between rubella in the mother and definite developmental stigmas in the infant, including congenital cataract especially, more and more instances are being reported in the literature. In 1944 Swan⁶ stated that if a woman contracted rubella within two months of pregnancy the chances of her bearing a congenitally defective infant appeared to be about 100 per cent. Since then, the consensus regarding frequency of congenital defects during the first trimester of pregnancy has changed until in 1947, Wesselhoeft⁷ stated that a woman contracting rubella had about one chance in ten of being delivered of a congenitally defective child. The recent preliminary report by Dr. Herbert C. Miller^{1b} and his Committee shows that of 89 children whose mothers had rubella during the first three months of pregnancy, 51 showed cataract formation. The highest incidence occurred in those cases in which the disease was present between the fifth and eighth week, and no evidence of cataract formation was found when rubella occurred after the third month of pregnancy. With fetal morbidity apparently fairly high, it has been suggested that all

young girls be exposed to rubella as a prophylactic measure. Certainly, in the case of any woman who has an unquestionable diagnosis of rubella in the first three months of pregnancy, be on guard for a congenitally defective infant.

Retrolental Fibroplasia

Another condition involving the crystalline lens is retrolental fibroplasia, which is responsible for one third of all cases of blindness in preschool children. First named in 1942 by Terry,^{8a} it is a disease occurring only in premature infants. As described by Reese,⁹ an opaque fibrous tissue extends over the posterior surface of the lens after birth and the globe is often smaller than normal. The anterior chamber is frequently shallow, and occasional posterior synechiae form. Elongated ciliary processes, appearing like coarse teeth of a comb, can be seen behind the iris, on the membrane in the extreme periphery of the dilated pupil. In premature infants both eyes are usually involved, but not always to the same extent. In some eyes the retrolental membrane may be incomplete and cover only a localized portion of the retrolental space. In others the membrane may be limited to the periphery of the anterior vitreous at the equator of the lens. The resultant contraction leads invariably to detachment of the retina, sometimes complete, with old and recent hemorrhages in all stages of organization.

There has been an apparent increase in the incidence of retrolental fibroplasia in the last few years, possibly due to increased survival of babies whose birth weights were 1,814 Gm. or less. Terry,^{8b} in 1945, stated that Clifford had found in a series of less than 50 infants at the Boston Lying-In Hospital an incidence of retrolental fibroplasia of 12 per cent in infants weighing 1,307 Gm. or less at birth. In 1948, Allers¹⁰ is quoted as saying that in 23 per cent of the infants weighing 2 to 3 pounds at birth at the same hospital retrolental fibroplasia developed. Owens and Owens^{11a} found in premature infants born between 1945 and 1947 at the Johns Hopkins Hospital 5 cases of retrolental fibroplasia in 61 observed cases with birth weights of 1,699 Gm. or less. Gilger¹² surveyed 229 prematurely born children weighing less than 2,268 Gm. at birth from January 1943 to January 1948 in Cincinnati. No cases of retrolental fibroplasia were found in the group weighing above 1,814 Gm. at birth, while in 96 with birth weights of 1,814 Gm. or less, 7 or 7.3 per cent had retrolental fibroplasia. Krause¹³ reported an increasing fre-

quency in surviving premature infants with a birth weight below 1,500 Gm., showing 11 per cent in 1945, 36 per cent in 1946, 45 per cent in 1947 and 86 per cent in 1948.

Retrolental fibroplasia is not present at birth. External appearances of the eyes, and the fundi are normal and without anything distinguishing. The earliest detectable abnormality occurring about three to five weeks after birth is a slight dilation of the retinal veins with an increased tortuosity of the retinal arterioles. This is soon followed by one or more grayish yellow elevations of the retina in the periphery. The vitreous becomes cloudy, and proliferating fibrous bands extend forward from the elevated retina into the vitreous. The retrolental membrane is formed by the fusion of the vitreous bands and the peripheral folds of swollen elevated retina. The active phase of the disease usually stops between the fourth and fifth month of the infant's life, the changes that occur after this time being due to contracture of previously formed fibrous tissue. If the membrane behind the lens is complete, all vision is lost. In no affected eye is vision normal or near normal. Often the eye is microphthalmic. Apparently the end result depends on the time the etiologic agent affected the organic system. The eyes are often highly myopic with disseminated areas of irregular pigmentation, to allow of some vision, enough to walk alone or to play with toys. Both eyes are usually affected, but often to varying degrees, as the membrane may be complete in one eye and partial in the other.

The main problem in retrolental fibroplasia is the prophylaxis of the disease rather than treatment in the late stages when irreversible damage has been done to the retina. Operations to remove the membrane have been unsuccessful.

The disease develops only in the smaller premature infants in early postnatal life, between the second and fifth months. At this time these infants are often given diets relatively high in protein and low in fat, large amounts of vitamin, repeated blood plasma transfusion, parenteral amino acids, and occasionally hormone therapy. The low fat diet¹⁴ is given because of defective fat metabolism by the premature infant, while high proteins are utilized efficiently. In the low fat diet, there is little of the fat-soluble vitamins, A, D, K and E. Usually A and D have been provided routinely in large doses, while K is usually given shortly after birth. Vitamin E alone of the fat-soluble vitamins

has not routinely been included in the vitamin supplements of premature infants. In addition to the low amount of vitamin E available in the reduced fat diets and the poor absorption of fat-soluble substances by the premature infant, the amount of available vitamin E may be even further reduced by the vitamin A supplements usually given, and by the use of iron to overcome the anemia which develops in premature infants in postnatal life. All this suggested to Owens and Owens^{11b} that supplements of vitamin E might prove to be a factor in the prevention of retrolental fibroplasia. In their study still in progress, the results in the prophylaxis of retrolental fibroplasia indicate the high probability that the solution to the etiologic factor may be found in the role of vitamin E in human nutrition. Thus far in their study, retrolental fibroplasia has developed in only 1 of 23 infants who received a vitamin E supplement, an incidence of 4.4 per cent. This infant was apneic, cyanotic and not expected to survive; the vitamin E supplement could not be started until the eleventh day. Of the 78 infants who did not receive vitamin E supplements, in 17 or 21.8 per cent, retrolental fibroplasia developed. This investigation will bear watching by you who have the care of the premature infant. It may well be that you, and not the ophthalmologist, will soon have in your hands the means of preventing this increasingly prevalent cause of blindness in children.

Toxoplasmosis

Our final consideration is toxoplasmosis,¹⁵ an infection by a protozoan parasite which is widely distributed throughout many countries of the world including the United States. It occurs in mammals, birds, Amphibia, reptiles and fish. Spontaneous cases have been reported in domestic animals, including the dog and fowl, while mice and rats form an extensive reservoir of the parasite. How the infection is transmitted is not yet known. Possibly the mouse and rat are important carriers; ticks have been suggested as possible insect vectors between animals, and between animals and man. It is interesting that Janku,¹⁰ an ophthalmologist of Prague, described the first case of toxoplasmosis in a human being. Since then, human cases have been reported in increasing frequency in the past ten years. It is because of the predilection of this disease for the eye that it is being given an important place in this consideration of medical aspects of blindness in children. It is the likely cause of conditions frequently encountered in infants and

children, with healed areas of chorioretinitis, the cause of which was unknown, and which in the past were called fetal chorioretinal infection, or congenital developmental anomaly of the retina and choroid, or birth injury with hemorrhage.

Toxoplasmosis was not recognized as a possible cause until 1937 when Wolf and Cowen,¹⁷ described a patient with congenital toxoplasmic encephalomyelitis in which antenatal inflammation was present in both eyes. The characteristic disturbances¹⁸ are found in the posterior segment of the eye and consist of a focal chorioretinitis usually affecting both macular regions as well as areas elsewhere in the fundi, caused by direct transplacental infection of the choroid and retina by toxoplasma. Searching nystagmus, deviation of the eyes and other effects of arrested or abnormal ocular development are also common. Gross persistence of pupillary membrane may be a feature as well as posterior cortical cataract, iridocyclitis, or some degree of optic atrophy secondary to the retinal damage or postneuritic from the internal hydrocephalus (usually present in 80 per cent of infantile cases). This specific involvement of the macular areas, and frequently of the optic nerve, all adds up to poor vision within our definition of blindness. The diagnosis must be suspected in the patient who has a history of convulsions, who shows on roentgen examination curvilinear or dust-like calcified areas scattered throughout the cerebral cortex, as well as in the basal ganglia and thalami, and who also shows the typical, large, sharply demarcated punched out white areas of choroidoretinal atrophy, usually bilateral and involving the macular area. Not one, or two, but all three of these factors must be present. Serum reaction, complement fixation and antibody fixation tests are also valuable aids to diagnosis.

There is no prospect of improving the retina that may be already destroyed, but sulfonamides, combined with emetine are effective in the active stage of the disease. Children may be treated in the active stage of the disease, and the mother may be treated during or before other pregnancies to prevent extension of the disease to the offspring.

Conclusion

This concludes the presentation of a subject that should be of concern to all in medicine, and especially to you who see the patients with these diseases before the ophthalmologist does. There is no tragedy more poignant than blindness in chil-

dren, nor any aspect of preventive medicine more deserving of your attention.

In the discussion of the medical aspects of blindness in children, particular reference is made to infectious diseases, injuries, congenital defects, especially congenital cataracts associated with rubella, retrolental fibroplasia and toxoplasmosis.

Discussion

DR. SHERMAN B. FORBES, Tampa: First, I congratulate Dr. Rubin on the presentation of not only an interesting but also a timely paper. The subject is of tremendous scope. The text of the paper is, however, largely confined to three ocular conditions of prenatal origin.

The exact time most suitable for operating in cases of congenital cataract is a moot question. I would say, generally, the earlier the operation is performed, the more chance there is for the prevention of amblyopia ex anopsia; however, the time of the operation does not always determine the final visual result as we do not entirely understand the rationale and prevention of amblyopia ex anopsia.

There has arisen the question of aborting the pregnant multipara who contracts rubella in order to prevent the almost certain congenital cataract in the offspring and often other defects in the mechanism of sight reception. Congenital cataracts, particularly these associated with maternal rubella, are frequently associated with other defects of the sight-receiving mechanism. The surgery of the congenital cataract associated with rubella in the mother is not always satisfactory as this cataract is especially doughy and hard to deliver.

The diagnosis of toxoplasmosis has been particularly difficult in the past years as the older tests have not been too satisfactory; however, the Sabin dye test offers real possibilities in early diagnosis. If the diagnosis were made early on the pregnant woman and sulonamide therapy instituted early, it might be possible that the defects in the offspring could be prevented. In the diagnosis of the established cases, large areas of old chorioretinitis in the macula and other regions of the fundi are sufficient if the roentgenograms of the skull show intracranial calcifications. These peripheral fundal lesions are usually symmetric in the two eyes.

ACTH (adrenocorticotrophic hormone) offers great possibilities in the treatment of certain diseases heretofore frequently resulting in blindness, such as uveitis, even the uveitis of sympathetic ophthalmia. This drug seems to be especially effective in the treatment of inflammatory tissue of mesodermal origin.

Retrolental fibroplasia, cases of which have been reported not only sporadically but lately in large numbers, usually develops in the infant of under 3 pounds in weight. The speculative question of causing the eyes to function too early arises. I have used vitamin E, or the mixed tocopherol or dextrotocopherol in 2 cases of retrolental fibroplasia with excellent general improvement in the infant but no alteration in the ocular condition.

In these cases of retrolental fibroplasia glaucoma usually develops. In 1 case of this type, at operation I used an iris inclusion procedure. The tension was controlled, and the patient was referred to Dr. A. B. Reese in New York for consultation as to the advisability of surgical removal of the membrane. This was decided against there, and the patient returned to Tampa. I agree with Dr. Rubin that surgery so far has offered little in retrolental fibroplasia.

After this brief discussion of the three conditions stressed by Dr. Rubin, it may be well to review ocular manifestations arising in the prenatal period by groups. Of the infectious processes, five may be mentioned: (1) syphilis; (2) toxoplasmosis; (3) tuberculosis; (4) rubella, and (5) ophthalmia neonatorum, a questionable member of this group as it is probably of natal origin.

In another group may be classed injuries to the brain or eye itself. Hemorrhage of the newborn would fall into this group, from whatever cause. Drugs may play a part

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Carcinoma of the Head and Neck

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AND

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TAMPA

The family physician has the greatest opportunity to save the life of the patient with cancer, for it is the family physician who sees the patient when the first symptoms have developed. The family physician is always on the alert to detect the early signs of cancer. The family physician influences the patient to seek early treatment. As a guide for the family physician, I want to review the early symptoms of the most frequent types of carcinoma of the head and neck, and to present something of what can be done to save the patient.

Carcinoma of the head and neck usually offers a better prognosis than does carcinoma elsewhere in the respiratory and gastrointestinal tract because these visible lesions are frequently diagnosed early and because their position is accessible to surgery or irradiation. This fact is well illustrated by carcinoma of the larynx, in which hoarseness occurs as an early symptom. The surgical excision of such early carcinomas of the larynx will produce better than 90 per cent five year cures. A relatively favorable prognosis is also presented by early lesions of the mouth, lips and tongue.

Even in the advanced carcinoma with cervical metastases, the carcinoma tends to remain localized within the head and neck. By combining local destruction of the lesion with block dissection of the cervical lymph nodes, we are able to salvage a gratifying percentage of the patients. We, as physicians, are too often inclined to regard such carcinoma as incurable; the plea of this presentation is to do everything possible to salvage the patient in cases of carcinoma of this type.

In practically all divisions of surgery, the present trend of treatment of cancer is toward radical excision. This trend has been influenced by disappointment in irradiation therapy and by the advent of sulfonamide therapy and antibiotics, the use of blood transfusions, and improved surgical and anesthetic technics. Although effective sur-

gery for cancer must, in some instances, be destructive, it can never be as destructive as the ravages of the carcinoma itself.

Carcinoma of the Larynx

Hoarseness is the early sign of intrinsic carcinoma of the larynx. Any patient with hoarseness persisting for two weeks should have a laryngoscopic examination. If this examination reveals any evidence of a suspicious lesion, biopsy should be performed. If an intrinsic carcinoma of the larynx is detected, the treatment of choice is surgical removal for, as previously discussed,¹ surgical removal will effect cure in a higher percentage of cases than will irradiation therapy. Surgical removal may be accomplished by a laryngofissure or a laryngectomy.

A laryngofissure is indicated when the lesion is limited to a single freely movable vocal cord. In a laryngofissure, the affected vocal cord is removed with a good surrounding margin of healthy tissue (fig. 1). The larynx is then closed, preserving the normal airway. In the first postoperative months, the patient talks with a forced whisper which is adequate for communication; later in the postoperative period, a cicatricial band develops which simulates the true vocal cord, and the patient eventually has a hoarse but functionally adequate voice. Technically, I prefer the Kemler or window type of laryngofissure,² with bilateral thyrotomy, as this type of laryngofissure offers an even more certain method of obtaining complete excision of the carcinoma (fig. 1).

A total laryngectomy is indicated when both vocal cords are involved (fig. 2), or when there is fixation of a single vocal cord. The laryngectomized patient must breathe through a permanent tracheostomy and he must learn new types of speech and communication. The laryngectomized patients with a stable personality usually make a remarkably rapid adjustment to the inconveniences of this malady. Having been relieved of the anxiety of an impending death from carcinoma, these

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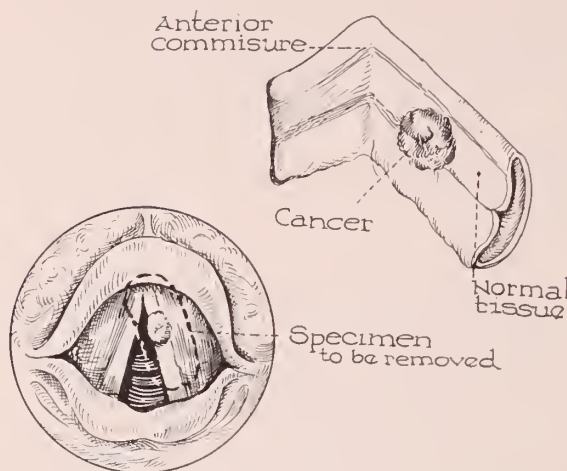


Fig. 1. Excision of early cancer of the vocal cord by laryngofissure will give better than 90 per cent five year cures.

patients are always extremely happy for their additional years and will often take pride in showing their new methods of speech and communication, as the electrolarynx, the artificial larynx or esophageal speech.

With early diagnosis, a laryngectomy should never be necessary. Through education of the public to the significance of hoarseness as an early sign of carcinoma of the larynx, and through the astute observation by the family physician, all carcinoma of the larynx should be detected at an early stage which can be cured by a laryngofissure; yet, a review of our recent cases of carcinoma of the larynx illustrates that the patients seek treatment too late, for in 8 out of 13 cases, a laryngectomy was necessary, and in only 5 could the lesion be removed with a laryngofissure. Brief reports of these cases will indicate the variable history of hoarseness.

Report of Cases

Case 1.—W. C., a man aged 73, presents a typical history of needless procrastination over a three year period. This patient received sundry treatments for hoarseness for eighteen months before cancer was suspected. A presumptive diagnosis of cancer was made, and the condition was regarded as hopeless. Three years after the onset, laryngeal obstruction developed, and the patient was referred for a tracheotomy. Examination revealed that the cancer was limited to the larynx and could, apparently, be removed by a laryngofissure. This was performed in August 1948. Using an electrolarynx, the patient has made a satisfactory adjustment and has enjoyed his additional years of life.

Case 2.—G. W., a man aged 75, presents an ideal history. This patient suffered from hoarseness following a cold. His general physician treated him for two weeks. The hoarseness did not improve; so the patient was referred to his laryngologist for examination. Mirror laryngoscopy revealed a probable cancer on the middle of the

right vocal cord, as in figure 1. In September 1948, a laryngofissure was performed, with removal of a Grade II infiltrating squamous cell carcinoma and apparent cure at nineteen months.

Case 3.—H. B., a man aged 83, thought that his hoarseness was due to a cold and did not consult a physician for more than one year. Laryngeal examination by his laryngologist revealed a carcinoma, as in figure 2, with fixation of one vocal cord. With a laryngectomy in September 1948, this patient has enjoyed an additional nineteen months of life. Now nearly 86 years of age, he works daily as a cabinet maker.

Case 4.—T. S. G., a man aged 78, complained of hoarseness for six months. His laryngologist found a carcinoma involving the anterior commissure and referred the patient for surgery. Hoping that a laryngofissure would suffice, a thyrotomy was performed in January 1949. This revealed subglottic extension on both vocal cords necessitating a laryngectomy. Five weeks postoperatively, the patient has not adjusted to his inconveniences. The laryngectomy has aggravated his alcoholism and depression.

Case 5.—S. W. C., a man aged 48, illustrates the dangerous type of history with "recurrent hoarseness." This patient complained of hoarseness for three weeks. Further inquiry revealed that the hoarseness had been recurring for more than six months. There was fixation of one vocal cord necessitating a laryngectomy in April 1949. The patient has not adjusted to his inconveniences. The laryngectomy has aggravated his alcoholism and depression.

Case 6.—B. L. S., a man aged 62, again illustrates the history of recurrent hoarseness. This patient had been hoarse off and on for four years. Reports of repeated laryngeal examinations were conflicting. Finally, his throat specialist referred the patient for laryngoscopy and biopsy. Examination revealed a Grade II squamous cell carcinoma involving all of the left vocal cord and the anterior half of the other. Again, a total laryngectomy was necessary to remove the carcinoma and was performed in July 1949. After a period of postoperative depression, this patient is making a fairly good adjustment.

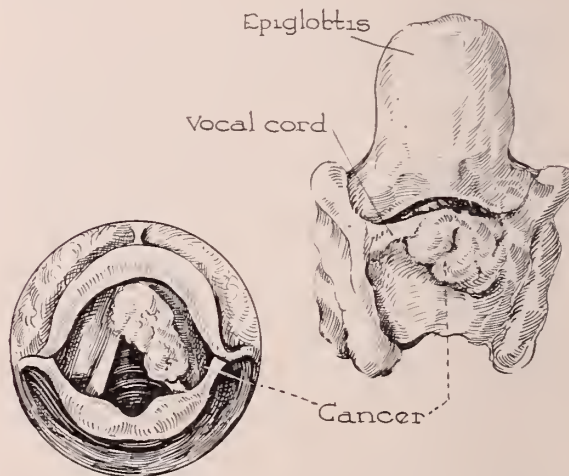


Fig. 2. Neglected hoarseness in cancer of the larynx means an extensive lesion necessitating a laryngectomy. There is still a 60 per cent possibility of obtaining a lasting cure.

Case 7.—V. B. B., a man aged 59, illustrates the tendency in adults for benign papillomas to become malignant. This patient had complained of hoarseness for three years. A biopsy two years earlier revealed a papilloma. Subsequently, the lesion continued to grow, producing fixation of one vocal cord and involvement of the

other. Biopsy and laryngectomy in July 1949 confirmed the diagnosis of an extensive infiltrating squamous cell carcinoma of Grade I malignancy. This patient has made a complete and rapid adjustment using esophageal speech.

Case 8.—O. V. C., a man aged 46, complained of hoarseness for two months. His history is the ideal. His general physician noted that his hoarseness did not respond to the usual treatment and had him consult a throat specialist. A growth on the vocal cord was found. The throat specialist referred the patient for laryngoscopy and biopsy in August 1949. Examination revealed an infiltrating squamous cell carcinoma of Grade III malignancy. This was removed with a Kemler type laryngofissure. The patient left the hospital on the fifth postoperative day and returned to work on the fourteenth postoperative day. Postoperative adjustment has been no problem. The patient works as a foreman; his voice is husky, but functionally adequate.

Case 9.—M. R. P., a man aged 49, complained of recurrent hoarseness and gave the dangerous history of a recent negative biopsy. Mirror laryngoscopy revealed a suspicious thickening of the anterior end of the right vocal cord. A second biopsy revealed Grade II infiltrating squamous cell carcinoma. A window type laryngofissure was performed in October 1949. The patient returned to work in three weeks.

Case 10.—A. B., a man aged 60, complained of hoarseness for one year. Laryngoscopy revealed a lesion on the border of a freely movable vocal cord. A window type laryngofissure was performed. Because of postoperative edema, a tracheotomy tube was inserted; after its removal, the patient made a rapid adjustment.

Case 11.—J. H. W., a man aged 65, complained of recurrent hoarseness for two and one-half years. A biopsy soon after the onset suggested suspicion of malignant disease. In spite of recurrent hoarseness, two years passed before the patient consulted another laryngologist. This time, in February 1950, biopsy of both vocal cords resulted in a report of Grade III infiltrating squamous cell carcinoma, necessitating a laryngectomy. The patient has made a rapid recovery and adjustment.

Case 12.—J. H. K., a man aged 77, complained of hoarseness for ten months. The hoarseness developed soon after a "stroke" and was attributed to a vocal cord paralysis. The hoarseness increased, and a laryngologist was consulted. Mirror laryngoscopy revealed a carcinoma producing complete fixation of one vocal cord and involvement of the anterior commissure of the other. Biopsy and subsequent laryngectomy in March 1950 revealed Grade II to III infiltrating squamous cell carcinoma.

Case 13.—H. C. P., a man aged 63, presents the ideal history of hoarseness of six weeks duration. He consulted his general physician, who immediately referred the patient for laryngoscopy. Laryngoscopy and biopsy in March 1950 revealed Grade II to III squamous cell carcinoma of the left vocal cord. The lesion was removed with a window type of laryngofissure. A lasting cure is expected for it is in this type of case (fig. 1) that we can obtain better than 90 per cent five year cures.

In this series, there have been no deaths. There has been no local recurrence of the carcinoma. The patient in case 1 presented carcinoma in the cervical lymph nodes after nineteen months. The cervical metastases were removed by block resection. The patient in case 5 with a psychopathic personality and alcoholism has made a poor adjustment; the remainder of the laryngectomized patients have adjusted well to their inconveniences.

Cancer of the Paranasal Sinuses

Any unusual swelling about the sinuses should be regarded as carcinoma until proved otherwise. Bloody nasal discharge and vague facial pains may indicate a cancer within the sinuses, but usually these lesions remain silent until they appear as a swelling of the face. Roentgen examination will reveal an expanding lesion within the sinus.

Because of their silent nature, diagnosis is late and the prognosis is grave. Irradiation alone has been disappointing. By combining complete excision of all the contents of the involved area with irradiation therapy, a worthwhile percentage of the patients can be salvaged.

Cancer of the Lip

Early cancer of the lip will respond to adequate surgery or irradiation therapy; yet, frequently, we see the needless recurrences from inadequate primary treatment. Almost every one here has removed early carcinoma of the lip with a V-shaped wedge of tissue. I want to make a plea for obtaining a wide margin of healthy tissue for, only too often, a recurrence or death results from the needless preservation of a few millimeters of tissue.

In surgery of the lip, there are many satisfactory plastic procedures for the removal of large lesions, angle lesions and recurring lesions. The following illustrative case demonstrates a recurrence which necessitated the complete excision of the lower lip, the reconstruction of a lip from a cheek flap (fig. 3), and a suprahyoid neck dissection.

Case 14.—R. G. S., a man aged 68, presented a small squamous cell carcinoma of the lip which was excised superficially in April 1949. On re-examination in September 1949, there was deep infiltration of the central two thirds of the lower lip. The entire lower lip was excised to the chin. A lip was reconstructed from a left cheek flap (fig. 3). Subsequent suprahyoid dissection removed metastases from the cervical lymph nodes.

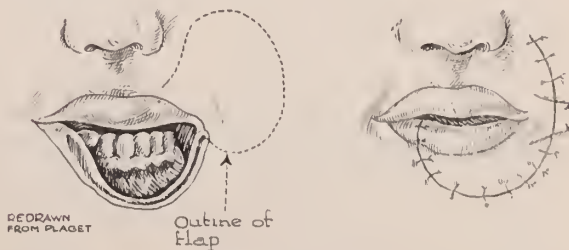


Fig. 3. Inadequate primary treatment of cancer of the lip necessitates radical excision and plastic reconstruction.

Cancer of the Mouth

Ulceration or Induration

Any suspicious ulcerated or indurated growth within the mouth should be subjected to biopsy. Cancer is, by far, the most frequent cause for such an ulcerated indurated area. Cancer can be definitely excluded only by biopsy. There is no time for procrastination. With biopsy and early diagnosis, we can obtain a high percentage of cures of carcinoma of the mouth. Early lesions in the soft parts, as the cheeks or anterior portion of the tongue, may be treated by irradiation or excision. When the bony structures are involved, irradiation is not as satisfactory as destruction of the lesion with electrocoagulation. I prefer the use of electrocoagulation, dessicating the entire lesion and underlying bony structure. The sequestrum may be subsequently removed.

In cancer of the mouth, cervical metastases may occur early or late. For this reason, I believe that block resections of the lymph-bearing structures of the neck should be carried out in all except the most simple lesions of the mouth. Only too frequently do we see cases in which the primary lesion has been beautifully removed; yet the patient returns at a later date with inoperable cervical metastases. It is for this reason that I recommend what may be called prophylactic neck dissections.

Cancer of the Pharynx

Silent Metastases

Cancer of the pharynx, nasopharynx and base of the tongue is usually a silent, highly malignant neoplasm in which cervical metastases are frequently the first evidence of the carcinoma. This lesion can be treated only by irradiation. The prognosis is poor.

Cancer of the nasopharynx is a silent lesion. It may produce unilateral aural symptoms through obstruction of the eustachian tube, unilateral nasal obstruction or bloody nasal discharge. Late in the course of the disease, there is invasion of the base of the skull. When there is unilateral enlargement of the cervical lymph nodes, a lesion in the nasopharynx should be suspected.

Cancer of the oropharynx and base of the tongue is an insidious lesion which does not produce symptoms until there is secondary infection. There is then a low grade sore throat, usually unilateral. The indurated ulcerated area may be detected by direct inspection, palpation or examination with a laryngeal mirror.

The treatment of choice of the lesions of the

pharynx is irradiation therapy, usually in the form of roentgen therapy, supplemented by interstitial radium therapy.

Cervical Metastases

Block dissection of all involved lymph-bearing structures in the neck is the treatment of choice of cervical metastases from cancer of the head and neck. When the primary lesion is situated on the lip or in the anterior part of the floor of the mouth, a bilateral suprahyoid neck dissection is indicated. When the lesion is unilateral, a unilateral block dissection of the neck is indicated.

In the suprahyoid neck dissection (fig. 4), the incision extends from one mastoid process to the other. The skin of the suprahyoid region is reflected up to the margin of the mandible. All lymph-bearing structures from one carotid sheath to the other are removed, including the submaxillary salivary glands.

In the unilateral block dissection of the neck (fig. 5), all lymph-bearing structures from the clavicle to the mandible are removed. The incisions extend from the mastoid tip to the sternum and from the chin to the shoulder. After elevation of the skin flaps, the internal jugular vein is ligated and the sternomastoid muscle is severed from its lower attachments. The sternomastoid muscle, the internal jugular and all lymph-bearing structures are then dissected away from the carotid sheath, the brachial plexus and the scalenus muscles. As the dissection is carried upward, a suprahyoid dissection is completed to the anterior belly

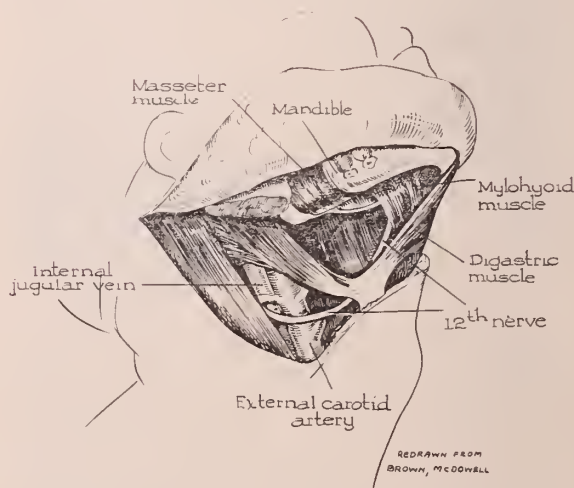


Fig. 4. Bilateral suprahyoid neck resection is the treatment of choice for upper cervical metastases from central lesions of the mouth and lip.

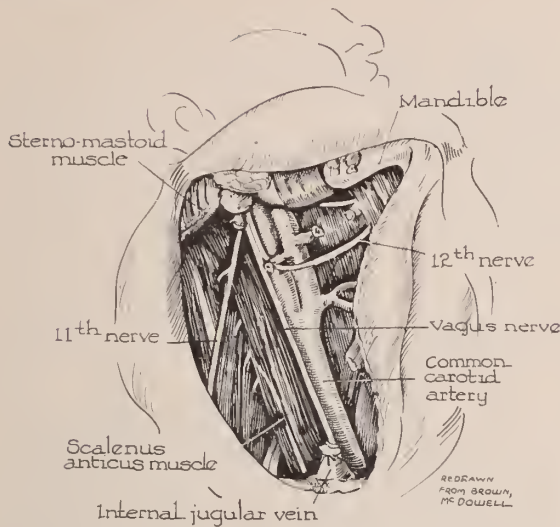


Fig. 5. Complete unilateral neck resection is the treatment of choice for cervical metastases along the carotid sheath.

of the digastric muscle of the opposite side. The attachment of the sternomastoid muscle is elevated from the tip of the mastoid, the lower part of the parotid gland is removed, and the fascia is severed along the lower border of the mandible. The jugular vein is ligated at the jugular foramen. The end result is an L-shaped specimen containing all the lymph-bearing structures on one side of the neck. Absolute hemostasis is necessary before closure, and a pressure dressing is utilized to maintain approximation of the skin flaps for the first post-operative days.

Summary

Through early detection of the lesion, the family physician has the greatest opportunity to save the life of the patient with cancer.

Hoarseness is an early symptom of cancer of the larynx. This disease is best treated by laryngofissure or laryngectomy. Thirteen cases are presented.

Swelling of the cheek, loose teeth or bloody nasal discharge may indicate cancer of the sinuses.

Any suspicious ulcerated or indurated area in the mouth, lip or tongue should be subjected to biopsy without procrastination.

Cancer of the pharynx is insidious in onset and may not be diagnosed until cervical metastases have occurred. The prognosis is poor.

When the primary lesion can be controlled, cervical metastases are best treated by block dissection of the lymph-bearing structures of the neck.

With present day anesthetic technic and improvements in preoperative and postoperative care, old age should not be considered as a contraindication to cancer surgery.

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Discussion

DR. C. FRANK CHUNN, Tampa: Dr. Farrior has asked me to carry this discussion one step further and briefly mention to you the lesions of carcinoma of the esophagus.

Carcinoma of the esophagus is probably of as frequent occurrence as all cancers of the lip, tongue, larynx or kidney. Cancer of the esophagus resembles the intraoral group of cancers more than it does the gastrointestinal cancers of glandular origin. This resemblance is evident in three ways: (1) the epidermoid carcinoma is the common histologic type, (2) the age and sex are strikingly similar, and (3) there seems to be a common etiologic relationship to chronic irritants. Because of the increasing knowledge of these factors, carcinoma of the esophagus may become one of the preventable cancers.

Heretofore, carcinoma of the esophagus has been diagnosed extremely late, the average delay being from nine to twelve months after symptoms appear. If, however, we as physicians will be cognizant of the fact that these lesions may be present with certain systemic changes and symptoms, then diagnosis of cancer of the esophagus is relatively easy. Every physician who suspects possible carcinoma of the esophagus should have a barium swallow roentgen examination of the esophagus in question. This examination combined with esophagoscopy examination is accurate in 95 per cent of cases.

Members of the Association who desire space for Scientific Exhibits at the Seventy-Seventh annual meeting in Hollywood, April 22-25, are requested to write Box 1018, Jacksonville, without delay.

Corneal Section And Suture In Cataract Operation

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JACKSONVILLE

Corneal section, figuratively speaking, might be said to have been performed by the early Chinese in 2737 B.C. It was then known as the needling operation, first mentioned in the writings of the Han Dynasty. Again, one finds it recorded under the same headings in the writings of the Babylonians, 668 B.C., but no records were made of the procedure, although couching probably was done. The first detailed description was given during the Roman period by Celsus, who recounted the couching operation step by step.¹

Through the centuries that followed there was no progress in ophthalmology until the eighteenth century. In 1705 Michael Brisseau and in 1707 Antoine Maitre-Jan, working separately, brought out the fact that true cataract is a clouding and a hardening of the lens. This was the first great discovery in ophthalmology. In spite of this forward step no further progress was made until 1722 when Charles St. Yves, while performing a couching operation, dislocated the lens into the anterior chamber. He opened the cornea and delivered the lens in capsule, the first intracapsular operation. The credit for the first planned cataract operation, however, goes to Daviel. In 1722 he sectioned the cornea below with forceps, dislocated the lens into the anterior chamber and expressed it from the eye; he therefore gets credit for inventing the modern cataract operation.¹

During the same year De la Faye suggested that section be made with a knife and also that the lens be removed in capsule. It remained, however, for Sharp of Guy's Hospital in London, also in 1722, to act upon the suggestion and to perform the first cataract section with a knife, at the same time suggesting that a special knife for this purpose be devised; hence, the forerunner of the modern cataract knife. Probably acting upon this suggestion, Joseph Beer of Vienna that same year brought out his triangular-shaped knife. Santorelli

in 1795 began to make the section in the upper cord of the cornea.¹

During the nineteenth century there was a great surge in the advancement of ophthalmology. About 1865 Von Graefe² produced the cataract knife which bears his name today. Von Graefe,² Critchett² and Panas² each described different corneal sections, along with Williams² of Harvard in 1867, Mendoza³ in 1892 and Kalt⁴ in 1894.

During the first two decades of the twentieth century there was little change. Cataract section at first consisted of section at the limbus with the cataract knife, later included the conjunctival flap, and finally the conjunctival flap and sutures.

Classification

For the sake of a better grasp of the many changes that are taking place in the present century, it is well to consider corneal section and suture under the following classification:

- I. Section with or without conjunctival flap, no suture.
- II. Section with superficially placed suture.
- III. Section with deeply placed suture.
 - A. Before section
 1. Extrasectional
 2. Intrasectional
 - B. After section

Section without suture will not be discussed.

Section With Superficially Placed Suture

CONJUNCTIVAL.—As near as can be determined, Williams² in 1867 was the first to suggest and use sutures. His suggestion for the use of conjunctival sutures after the cataract operation was not generally accepted, and many in this audience can recall that most ophthalmic surgeons during the first and second decades and some in the third decade of this century used no suture of any kind. Barraquer⁵ in 1923 and Greene^{2b} in 1925 began to advocate the use of the conjunctival suture. In

¹Read before the Florida Society of Ophthalmology and Otolaryngology, Tenth Annual Meeting, Belleair, April 10, 1949.

1925, Berens^{2b} with his trickily placed conjunctival suture and about the same time Verhoeff⁹ strongly advocated the use of this type of suture. The conjunctival flap also had its advocates, notably Van Lint⁷ in 1930. Verhoeff,^{9,8} not satisfied with his strictly conjunctival suture, developed a suture in which he placed the original double-armed suture transversely in the substance of the cornea after dissecting upward a conjunctival flap from the limbus and passing the double-armed sutures longitudinally underneath the conjunctiva, thus bringing it down as a conjunctival flap over the section after completion of the operation.

Section with Deeply Placed Suture

BEFORE SECTION: EXTRASECTIONAL. — Sutures placed before the section is begun, designated in the classification as extrasectional sutures, constitute no new procedure. Kalt⁴ in 1894 first used the corneoscleral preplaced suture. He used a vertical bite in the cornea coming out 1 mm. below the limbus with a transverse bite in the sclera above, forming roughly a T when tied. As is usual with most far advanced thinking and procedure in medicine, this suture was not accepted by the profession.

There is little reference to any preplaced corneal sutures until the writings of Ellett⁹ in 1937, Stallard¹⁰ in 1938, and Leech and Sugar¹¹ in 1939. They emphasized the mattress suture, which is ably described in modified form in O'Brien's work¹² in 1947. This suture takes a transverse bite in clear cornea, 3 to 4 mm. in width, 1½ mm. below the limbus, and a corresponding transverse bite in the sclera 1 to 2 mm. above the limbus. The original suture of Ellett,⁹ Stallard,¹⁰ and Leech and Sugar¹¹ was modified by Searcy¹³ in 1941. He began his suture above the limbus going outward at an angle of 45 degrees, taking the usual bite through clear cornea and coming back through the sclera at an angle of 135 degrees so that there would be a small area to tie. In his opinion better closure is obtained with this suture than with the usual mattress suture. Dyar,¹⁴ in 1947, further modified the original Stallard or mattress suture in that he dissected the conjunctiva above at the limbus, placed his suture at 10:30 and 1:30 o'clock in clear cornea transversely, and longitudinally above the limbus in the sclera, then out through the conjunctiva to form a flap over the section.

ADVANTAGES AND DISADVANTAGES. — There is, as I see it, only one advantage of the extrasectional mattress suture: (1) It is easily and quickly

placed. There are some disadvantages: (1) It cannot be tied tight because of the chance of overriding, inversion or eversion of the sectional margins, resulting in (2) more frequent loss of the anterior chamber through leakage, with a soft eye and the usual complications that go with it.

BEFORE SECTION: INTRASECTIONAL. — Like the extrasectional suture, the intrasectional is no new achievement. It was first suggested by Mendoza³ in 1892. He used the first preplaced suture in cornea. His section, however, was in clear cornea below the limbus or at the limbus. So Kalt⁴ in 1894 was the first to develop the corneoscleral preplaced suture, and Mendoza³ has the distinction of suggesting the first preplaced suture. This suggestion also, as with others, was not followed up.

In 1940, McLean,¹⁵ in his excellent article describing his suture, gave these requirements for a preplaced suture:

It should be inserted in solid corneal and scleral tissue and not in loose, yielding conjunctiva. It should be placed before the section is made and should not require extensive manipulations after the eye is opened. It should go through, not over, the lips of the wound, so as to give firm closure without danger of inversion of the edges, and it should be so placed that when tied it will bring the tissues back to exactly the preoperative position. The entire wound should be covered by conjunctiva as an added protection and better surgical closure.

He makes his scleral section with the Lundsgaard knife, after laying down a 3 mm. conjunctival flap above, beginning 1 mm. above the limbus and going about halfway through. The needle is passed through the flap at its base from below upward, reversed, and run through the upper or scleral lip 1 mm. from the cut edge passing through from above into the section, and then through the lower or corneal lip just beneath the entrance of the original suture so that there will be approximately a distance of 1 mm. between the two. The strand of suture lying in the wound is then gently drawn aside and sections completed.

Weeks,¹⁶ in 1942, described his method. He makes the usual section with a cataract knife with or without flap. He leaves a small bridge of uncut sclera at the 12 o'clock position without; the suture is then placed through the cut edges of cornea and sclera on either side of the uncut bridge as close to it as possible, allowing sufficient room to complete the cut with a pair of scissors. When a flap is used, the usual McLean procedure is followed.

Hymes,¹⁷ in 1945, modified the McLean method. He uses the flap, the usual incision with the Lundsgaard knife, or a special concave curved

knife, as he describes. He passes the suture through the flap, then through the lower corneal lip, through the section, through the upper scleral portion, and out and through the conjunctiva, after which that portion of the suture in the wound is gently drawn aside so that section can be complete.

Using the McLean technic, De Roeth¹⁸ found that he had some difficulty with the flap in placing the suture and making the section. In 1946 he modified the operation still further in that he makes the conjunctival opening longitudinal instead of horizontal. He places his scleral incision as does McLean. The suture placed at the upper edge of the corneal incision is simply a suture through the cornea coming out in the edge of the section and on through the edge of the sclera. That portion of the suture in the section is gently pulled to one side. Then the incision for the corneal section is made with a cataract knife, and a large conjunctival flap is obtained along with the section.

Advantages and Disadvantages.—There are some advantages in placing the suture before the section is made: (1) The suture is placed in solid cornea and sclera. (2) It goes through the sectional edges in true apposition. This feature assures returning of the various parts to their original site. (3) There is also a good conjunctival flap. There are likewise disadvantages: (1) There is difficulty with the flap when the section is made. (2) There is always the danger of cutting the sutures. (3) Usually only one suture is used to close. (4) The removal of the suture postoperatively is hazardous. In from 2 to 3 per cent of the cases there is loss of the anterior chamber at this time.

Atkinson,¹⁹ in his noteworthy article published in 1946, gave the first good reason why one should use the superficial rather than the deep sections. In the illustrations shown in his article the limbus of the cornea is much higher than is usually expected. This author advocated strongly the use of the keratome rather than the cataract knife because (1) it is easy for all ophthalmic surgeons to use and control, and (2) enlargement with scissors gives a more uniform section and is easier to control. In figure 2 of his illustrations the keratome is pointed upward toward the center of the cornea. In this way a broad beveled posterior lip is obtained, which will cover the upper portion of the lens. To use this section, one must tumble the lens, and there is a word of caution. For enlarging

the sections nasally and temporally, the scissors should be held almost flat with the keratome section. The lower section is then more conventional; probably it is used by the greater number of surgeons also. I should like to direct attention to the area between the sections made by the keratomes. The illustration shows how the cornea invaginates the sclera. The limbus is some distance above the angle of the eye. The blood supply of the anterior chamber segment of the eye is formed by the long posterior ciliary arteries and the anterior ciliary arteries anastomosing to form the major arterial circle. This anastomosis gives all branches to the angles of the limbus and shows why hemorrhages occasionally occur when deep sections are made. There is a relatively avascular space which lies just beneath the limbus. Utilization of this space with superficial sections results in less hemorrhage and more satisfactory healing of the wound.

AFTER SECTION: INTRASECTIONAL.—Barraquer,⁵ in 1938, advocated sutures placed in the section through the edges. He uses one suture at 10 and one at 1:30 o'clock. After section is made, the suture is started in clear cornea 1 mm. from the cut edge, passing through and coming out in the middle of the sectional edge. The scleral edge is gripped and the needle then passed through the middle of the section and out 1 mm. from the cut edge, in exactly the same plane. This procedure assures exact replacement of parts with no distortion.

Verhoeff,⁸ in 1934, began experimenting and using his suture. It was described by Case,⁸ one of his students, in 1938, as follows: The conjunctiva is dissected loose at the limbus and reflected upward. The needle is placed vertically in clear cornea beginning 1 mm. below the limbus, passes intracorneally through the limbus and comes out above approximately 1 mm. beyond in sclera. Two sutures, one at 10:30 and one at 1:30 o'clock, are used. The section is then made, and the sutures are cut at the same time. After the section is made, a third and fourth suture then are rethreaded along the side of the cut sutures. The loop is drawn out and made ready to tie.

Kirby,²⁰ in 1941, published his monograph. He advocates section by keratome or by cataract knife as the surgeon chooses and he modifies the Barraquer technic in that he places three sutures. His two wing sutures are placed at 10 and 2 o'clock, and the first loop of the tie is made. The center suture is also placed at 12 o'clock. This

suture is placed only in the cornea and is not completed; it is used to elevate the cornea so that the entire section, the lens and the iris can be inspected. He has shown that this procedure in no way affects the cornea.

Advantages and Disadvantages.— This method offers several advantages: (1) The sutures are placed in solid cornea and sclera. (2) They are intrasectional, in line with the radius at the point of selection. (3) They give a water-tight wound with early formation of the anterior chamber. (4) There is a small conjunctival flap present. (5) The suture is easily removable. Disadvantages include: (1) The full section is made before sutures are introduced. There is a chance with this procedure that the globe will be distorted, causing dislocation of the lens and presentation of the vitreous before the surgeon is ready. (2) There are only two lateral sutures ready for tying. The middle suture has to be completed after the extraction of the lens. In some cases this necessity is embarrassing.

Richardson Modification of Kirby Method, with Further Modifications

In 1946 when I returned to the office after four years' absence, I found that my associates, Dr. Shaler Richardson and Dr. Walton B. Wall, Jr., had discarded the old conjunctival suture, as used in the early forties, and had adopted a modified Kirby method. I readily could see the advantage of the new technic over that of the old and adopted their procedure as mine. The section with the cataract knife was, however, adhered to until sometime in 1947, when it was completely dropped. In the Kirby method, two lateral sutures are placed and the first tie completed; the center suture is not completed. In the Richardson modification of the Kirby method, this suture is completed in an ingenious manner, and I shall describe the procedure in detail, with some modification. In the Kirby operation the section is completed in full. The sutures are placed as indicated. This procedure in Dr. Kirby's hands has been most successful, but in my hands introduction of the sutures with full section resulted in some distortion of the cornea and of the sclera, and I have seen vitreous present before the sutures were completed. This experience led me to certain modifications which, if tried, will, I believe, give rise to no difficulty.

First, the keratome section is made above. Before any enlargement is attempted, the middle intracorneal suture is placed as follows:

One millimeter of the corneal cut edge is grasped in heavy forceps and slightly everted. The point of the needle, attached to a full length suture, is passed as close to the forceps as possible, beginning 1 mm. below, coming out in the middle of the section. The suture is pulled through a full three fourths, draped back over the cornea, across the cheek, down over the temporal area and around over the brow. The scleral section, in the same plane as the corneal suture, is grasped and slightly everted; the needle is passed through its middle portion coming out above 1 mm. from its edge. The conjunctiva is also engaged at this time.

Two gauze squares are utilized, one over the brow and one over the cheek covering the suture, so that only that portion doubled back over the cornea is left exposed for use as a retractor of the corneal flap. This procedure is used for two reasons. It hides this long continuous suture when not in use. It prevents the surgeon or assistant from grasping the wrong suture for tying in an emergency, yet in no way detracts from the operative procedure.

The section next is enlarged nasally because this suture is the hardest mechanically to place, and then only to the point where the suture is to be placed. The section is extended temporally, the third suture is placed, and the first knot in the two lateral sutures is made. The section on either side can be enlarged as much as necessary.

Advantages and Disadvantages.— The advantages of this procedure are: (1) The middle suture is in place for elevation of the corneal flap when inspection of the anterior chamber is desired and yet completely removed for any operative manipulation. (2) All sutures are placed in solid cornea and sclera in direct apposition in the same plane. (3) There is no distortion of the globe in the placing of the suture. (4) There is a small conjunctival flap. (5) All sutures are placed before extraction, and the first knot is placed in the two lateral sutures ready for immediate tying at the instant extraction is completed. (6) The sutures are easily removed. (7) The anterior chamber is formed early as a result of the water-tight fit. The disadvantage of this procedure is that it is not placed before the section is made.

Summary

Corneal and corneoscleral sutures are not new. They were suggested and used late in the nineteenth century.

Corneal closure came into general use about

the third decade of the twentieth century, first in the form of conjunctival sutures or bridges and progressing to corneoscleral (1) preplaced before section is made and (2) preplaced after section is made.

The various types of suture, their advantages and disadvantages are discussed. The Richardson modification of the Kirby method is described, together with further modifications I have found useful.

Conclusions

1. Corneoscleral sutures are most advantageous in that they have (1) reduced postoperative complications, (2) mobilized the patient at an early date postoperatively, and (3) shortened the period of hospitalization.

2. Preplaced sutures are an advantage in certain expected complications, but they are much harder to handle than postplaced intracorneoscleral sutures and more difficult to remove postoperatively.

3. At the present time there is no ideal corneoscleral suture.

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The Scientific Department of The Journal
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On Data of Notable Interest

Mesenteric Thrombosis

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AND

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DAYTONA BEACH

Occlusion of a mesenteric artery or vein is one of the most dramatic conditions encountered in surgery. The exact cause is still obscure, but the pathology was described in detail by Virchow in 1871. Its incidence is greater between the ages of 40 and 70, although cases have been reported in infants and in adults up to 90 years of age. It is more prevalent in males by a ratio of 60 to 40. The exact diagnosis is seldom made until the patient is either operated on or autopsy is performed.

This anomaly is usually concomitant with a pre-existing circulatory disturbance, but may be a complication following an infectious process; particularly of the appendix, or trauma of the viscera incident to extensive surgery, injudicious handling, or retraction pressure. The arterial circulation is occluded more often than the venous. In the majority of the cases the superior mesenteric vessels are involved. The mortality is extremely high, either because the patient, suffering from some cardiac or circulatory condition, is already moribund, or because the treatment has been too long delayed.

Diagnosis of mesenteric vascular obstruction is difficult; the symptoms are essentially those of intestinal obstruction and peritoneal irritation. In cases of massive occlusion the element of obstruction may be overshadowed by signs of internal hemorrhage due to extravasation of blood from the infarcted loop of bowel. Some of this blood may be evident by hematemesis or melena.

Sudden obstruction of a major vessel in the mesentery dramatically exhibits an abdominal catastrophe, manifested by acute pain, nausea, vomiting and profound shock. In occlusions that develop more slowly there are three evident stages: (1) a period characterized by hyperperistalsis with colicky pain and nausea, (2) an interim of in-

testinal paresis which produces the syndrome of partial intestinal obstruction, and (3) a phase of total intestinal strangulation and maceration.

Prognosis depends on several factors, but the most important are: (1) the general condition of the patient as to his age, presence and degree of circulatory impairment, and (2) the early recognition of the existence of an acute surgical emergency. The last 2 cases of this report bear out the necessity of early recognition. While it cannot be said that early treatment would have altered the outcome, it could, however, be said that the patients would have had a better chance for recovery. In 1944 Ficarra¹ of New York compiled 569 cases from the available medical literature, with 35 successful resections. McClenahan and Fisher² reported 40 cases at Mercy Hospital of Pittsburgh out of 10,000 admissions during a five year period, with a mortality rate of 61 per cent. Forty-four cases³ at Michael Reese Hospital of Chicago were reported, covering a ten year period with a mortality rate of 73 per cent. Review of fifteen articles on this subject indicates that radical surgery with complete resection of the involved segment of bowel and end to end anastomosis is the only hope for survival in these cases. In a majority of them, however, the authors agree that in many cases the condition is undiagnosed and recovery takes place because of the minor degree of involvement and because collateral circulation is established before the segment of bowel undergoes ischemic degeneration.³

Report of Cases

Case 1. — A white woman aged 57 was admitted to the hospital on Nov. 27, 1947 complaining of severe epigastric pain, nausea and vomiting shortly after breakfast. There was a long history of allergic manifestations to food, eczematoid eruptions following dietary indiscretions, and poor appetite. There had been a pelvic operation twenty years previously and a vaginal hysterectomy five years before this illness. The family history was noncontributory.

Physical examination revealed a poorly nourished, fragile-looking woman, who complained of constant abdominal pain. The temperature was 97.4 F., the pulse rate 92, and the rate of respiration 22. The blood pressure was 150 systolic and 100 diastolic. The cardiac sounds were distant, the muscular quality of the heart poor, and the rhythm normal. The abdomen was moderately distended, and tenderness was elicited on deep pressure in the epigastrium. Peristalsis was audible and normal.

The blood count was red blood cells 4.3 million and white blood cells 14,800, with polymorphonuclears 74, lymphocytes 18 and stab forms 8. Urinalysis gave negative results.

A diagnosis of acute biliary colic was made. The patient continued to vomit, and frequent doses of narcotics were necessary to relieve pain. Fluids were administered intravenously as she was unable to retain anything.

Although she felt better on the following morning, the pulse rate was 110 and the abdomen was more distended; peristalsis was still audible but subdued. The next morning her condition took a dramatic turn for the worse. The temperature was 100.3 F., the pulse rate was 120, the abdomen was distended, there was no muscle defense, and peristalsis was absent. The blood pressure was 110 systolic and 60 diastolic. The medical consultant agreed that an acute surgical emergency existed.

At operation, following a blood transfusion and administration of adequate intravenous fluids, about a quart of serosanguinous fluid was removed. A gangrenous length of ileum, measuring 6 feet and extending down to within 4 inches of the ileocecal valve, was excised, and end to end anastomosis was carried out. Upon examination of the mesentery, there was found a thick fibrous band binding the inferior mesenteric artery, no doubt the resultant of previous surgery.

After a stormy postoperative course lasting nine days, there was a sudden lowering of the temperature and decrease in the pulse rate. The patient began to complain of hunger. She was discharged on the twentieth day and has been well ever since.

Case 2.—A white carpenter aged 51 complained of severe abdominal cramps, nausea and vomiting when he was admitted to the hospital on June 23, 1949. At 5 o'clock that morning he had been awakened by sudden pain around the umbilicus, which was constant in character with occasional accentuation. He had felt like vomiting, but did not do so until he drank warm water. His past history and the family history were irrelevant. He had enjoyed excellent health and had worked hard all of his life.

Physical examination showed the patient to be exceptionally well developed, as a man who had performed manual labor. He was in acute pain. The temperature was 97.8 F., the pulse rate was 70, the rate of respiration was 20, and the blood pressure was 110 systolic and 70 diastolic. There was some voluntary muscle spasm of the abdomen, but no particular area of tenderness and no distention; peristalsis was normal and equally distributed over the entire abdomen.

At 8 a.m. the blood count was 4.5 million red blood cells and 8,400 white blood cells with 65 per cent polymorphonuclears. The count at 11:30 a.m. was white blood cells 10,200 and polymorphonuclears 79 per cent. Urinalysis gave negative results.

By 3:30 p.m. the abdomen was moderately distended, peristalsis was absent, and the patient complained of dull pain. At operation, twelve hours after the initial symptom, 4 feet of gangrenous mid ileum was removed, and end to end anastomosis was carried out.

The postoperative course was uneventful. Wangenstein suction was discontinued on the third day. The patient began to eat soft food on the fourth day, was up and around on the sixth day and walked from the hospital on the ninth day after admission. He remains in excellent health and has not missed a day's work since he was discharged from the hospital.

Case 3.—A white woman aged 72 was admitted to the hospital in a comatose state on Nov. 28, 1949. Relatives related that four days previously she had experienced violent abdominal cramps, nausea and vomiting, which a physician diagnosed as a biliary attack. The condition grew progressively worse, and on the fourth day after the onset another physician recommended immediate hospitalization.

On admission, the temperature was 101 F.; the pulse was thready and the rate 110; respirations were intermittent and the rate 30. The abdomen was distended, extremely tender to touch and silent. A diagnosis of mesenteric thrombosis was made.

After receiving a transfusion of 500 cc. of blood and intravenous injection of 2,000 cc. of saline and glucose, the patient was operated on. The entire small intestine 1 foot from the ligament of Treitz to within 4 inches of the ileocecal valve had undergone advanced gangrenous changes. Seventeen feet of intestine was resected, and end to end anastomosis was carried out. In spite of excellent nursing and all supportive measures, she died three days after the operation.

Case 4.—A 76 year old man was admitted to the Halifax District Hospital on Dec. 29, 1949 in a semicomatose condition with a history of sudden onset three days previously of severe epigastric and substernal pain accompanied by shock reaction, nausea and vomiting. His physician had made a diagnosis of myocardial infarction and ordered him to bed. Not until the third day were abdominal symptoms of pain and distention present, and he was then transferred from New Smyrna Beach to the hospital.

On admission, the hemoglobin was 15.8 Gm. and the white blood cells 29,500, with polymorphonuclears 92 per cent. Urinalysis disclosed 10 to 15 pus cells per high power field. Roentgen examination of the abdomen gave evidence of several loops of gas-filled intestine compatible with paralytic ileus or obstruction.

In preparation for operation the patient was given fluids for dehydration, and Wangenstein suction was instituted for distention. At operation, 6 to 8 feet of ileum in an advanced stage of gangrene was resected, and end to end anastomosis was carried out. The patient died seventy-two hours later, apparently of overwhelming toxemia.

Summary

Four cases of mesenteric thrombosis are reported. In each case it was demonstrated that:

1. Early surgical intervention is of paramount importance in the treatment of this condition.
2. Circulatory embarrassment of some type is concomitant in many cases with thrombosis of a mesenteric artery.
3. Mechanical strangulation of the root of the mesentery produces the same chain of symptoms and the same pathologic changes in the intestine; it also requires identical treatment.

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(Continued from page 354)

in prenatal ocular defects. I have observed cases in which quinine, ingested by the mother as an abortifacient, caused almost total blindness and deafness in the infant and have reported such cases, as have others.

The largest percentage of prenatal or natal ocular defects or early blindness is associated with developmental abnormalities. These include inherited dystrophies and abiotrophies. It is interesting to note that the phacomatoses belong in an intermediary group, seeming to partake of the nature of both deformities and diseases and being in a way developmental and neoplastic at the same time.

Is anything being accomplished for the control of the situation? A few conditions have been improved or eliminated by therapy, particularly syphilis, gonococcal infection, congenital cataract and congenital glaucoma.

Ophthalmologic genetics has been especially satisfactory with regard to albinism, nystagmus, color blindness, turricephaly, cataract, and corneal dystrophies in which the existence of several dominant and recessive biotypes is now established. Much work has been done on Marfan's syndrome (arachnodactyly), angiomatosis, retinal detachment, and angioid streaks. In my opinion, the answer is a great deal more study by embryologists, geneticists and pathologists. There could well be included in this illustrious group the obstetricians, the pediatricians and, primarily, the general practitioners. Questionnaires should be sent out in a sincere effort to determine whether or not the salvaging of the very premature infant is adding to the number of ocular and other defects.

How the two specialties, pediatrics and geriatrics, have changed; we are arriving earlier and staying later. In a national report, the etiology of 43 per cent of the cases of blindness was unknown. This fact emphasizes my previous statement as to the necessity of the family physicians and at least the geneticists collaborating in a program of prevention. It is they who can assemble the necessary family records of the more serious hereditary ocular defects and use the data to advise prospective parents. Until medical science develops methods for counteracting the effects of hereditary factors, application of nature's laws of genetics constitutes practically our only defense against hereditary blindness.

DR. RUBIN, concluding: I want to thank Dr. Forbes for his discussion. It is especially gratifying to have the blanks in my address filled in by such an eminent ophthalmologist as he. It has not been possible to touch more than a few aspects of this embracing subject. I am gratified as much as you must be for the added observations Dr. Forbes has made. As regards the not yet corroborated value of the benefit of vitamin E supplement in the prevention of retrolental fibroplasia, the Drs. Owens' series of cases is admittedly small, but nevertheless offers a means of attack against this dread disease that is hopeful. I want again to thank Dr. Forbes for his fine contribution to this subject, and to thank all of you for your patient attention

to a seemingly specialized subject that does have wide and general application.

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ABSTRACTS OF MEDICAL ARTICLES

THE INFLUENCE OF VAGAL ACTIVITY ON HEART BLOCK. By Addison L. Messer, M.D., Charles K. Donegan, M.D., and Edward S. Orgain, M.D. Am. Heart J. 38:732-742 (Nov.) 1949.

A series of 51 unselected cases of heart block associated with various etiologic factors was studied for the purpose of investigating the effect of vagal activity. In addition to electrocardiographic study of the entire series for changes in the P-R interval after the administration of atropine,

the effects of breathing 100 per cent oxygen and of the subcutaneous injection of acetyl-beta-methylcholine (Mecholyl) in 22 of the cases were analyzed and the results compared.

It was noted that both atropine and Mecholyl decreased the P-R interval in a majority of these cases, atropine being the more effective. The authors concluded that atropine, Mecholyl and oxygen are of no value in determining either the etiology of heart block or the underlying physiologic mechanisms in human subjects.

THE ELECTROCARDIOGRAM IN PNEUMOPERITONEUM, INCLUDING AUGMENTED UNIPOLAR LIMB LEADS AND UNIPOLAR CHEST AND ESOPHAGEAL LEADS. By Elwyn Evans and Thomas C. Black. *Am. Rev. Tuberc.* 61:335-345 (March) 1950.

A series of 10 cases is reported in which the patients, without suggestive evidence of cardiac disease, with pneumoperitoneum were studied with standard and augmented unipolar extremity electrocardiograms, numerous unipolar chest leads and esophageal leads, and with anteroposterior and lateral roentgenograms. Pneumoperitoneum with or without phrenic paresis affected the form of all leads to variable degrees, but the changes were not always predictable.

It was observed that pneumoperitoneum may form abnormal Q waves in the standard or unipolar limb leads or the esophageal leads. In all 10 cases, abnormally large Q waves, usually associated with abnormal T waves, were obtained in esophageal leads at ventricular levels. Interposition of air between the electrode and the heart did not appear to be the predominant factor in the production of the abnormally large esophageal Q waves. The position of the heart, however, especially forward displacement, was considered a probable factor in their production because the heart was displaced upward and forward in each case.

Assumption of the upright position generally caused an increase in the amplitude of the esophageal Q and R waves, the R more than the Q, so that the Q/R ratio was decreased. The T waves decreased in amplitude or became more deeply inverted.

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"Wilt Thou Be Made Whole?"

"Do you want your health restored?" This modern translation of the age-old question of the Great Physician, "Wilt thou be made whole?" would elicit hardly one negative reply today. Who does not covet good health? Too few, however, realize that the concept must include wholeness of mind and of spirit as well as of body.

As another holiday season approaches, it is fitting to reflect upon this goal, the integrated personality, whether individual or national. When one seeks to climb dangerous heights, it is wise to look up rather than down. Likewise, in public as well as personal realms of thinking there is need to develop healthiness and wholeness of mind by looking steadfastly upward. There is need to cast out the nationwide obsession about security and regain the courageous spirit of this country's pioneering founders who sought opportunity above and beyond security. They found incentive and inspiration not merely in preserving but also in improving and broadening.

There is need to turn upward from the abyss of self-centered preoccupation with the evils that threaten at home and abroad. There is need to seek that higher realm of the American dream, aptly called this nation's greatest contribution to the world. Envisioning a land where life shall be richer and better and fuller with opportunity for every person according to his ability and achievement, that dream, in this security-conscious age, must not be allowed to die.

Whole in body? In mind? In spirit? No one knows better than the physician the interdepend-

ence of these three. No one realizes more than he that America's phenomenal medical progress is vested in "the miracle of America itself — the motivating power of the American spirit, of free men, unshackled, and unfettered, with freedom to think, to create, to cross new frontiers."

Dingell's Jingle Soundly Rebuked

Recently, the American Medical Association launched its nationwide campaign to advertise the danger of socialized medicine. Between October 8 and 22, a bold-faced ad headed "Who Runs America?" appeared in 11,000 daily and weekly newspapers and 30 national magazines, while some 1,600 radio stations broadcast A. M. A.-sponsored announcements.

This advertising campaign, first in the history of American medicine and paid for by a \$25-a-year A. M. A. membership assessment, was launched by a special message from Dr. Elmer L. Henderson. "The President's Page, A Monthly Message" appeared as a new feature of The Journal of the American Medical Association in the September 23 issue:

... The American medical profession is in one of the most crucial and challenging periods of its history. On the civilian front it has taken the initiative in a determined crusade against socialistic threats to our basic American freedoms. We doctors have a powerful message of faith in the wisdom of free, informed, unregimented people. We are taking that message to EVERY American. ... The response ... has been gratifying beyond expectations. I wish that every doctor could ... read all the expressions of congratulation and promises of support. ... The National Association of Life Underwriters, with 52,000 members, is backing the program strongly. ... The Na-

tional Association of Chain Drug Stores, covering 5,000 local stores, has pledged all-out assistance. The National Retail Dry Goods Association, with more than 7,000 leading stores . . . has enlisted the active cooperation of all its members. . . .

More than 100 individual banks have indicated that they will advertise. The utilities are joining us, too. . . . At least one railroad [the Union Pacific] already is cooperating.

On September 12, Michigan's Representative John D. Dingell of Murray-Dingell notoriety observed in the Congressional Record under the title of "Help Fight Medical Lobby Twenty Million Dollar Smear Campaign:"

. . . This saturation campaign is designed to spread by massive injections of untruths, lies, distortions, and innuendoes, a contagious infection among our people so that they will fall victim to the big-lie technique of the medical lobby's . . . propagandists . . . to doctor, drug and slug the American people into believing the crude big lie that sickness is health, that insurance is socialism and communism, that the President's plan for national health insurance is socialized medicine. . . .

That statement, made up largely of fighting words, called for a rebuke which Dr. Henderson made promptly in a memorandum to all members of Congress. He wrote in part:

I believe *most American will consider this a gross misuse of a public document* . . . that Mr. Dingell's use of the Congressional Record in this fashion will be viewed by most citizens as a travesty on good taste, as evidence of opportunistic willingness to damage a medium of great public usefulness and dependability, for personal political purposes—and a descent into the very tactics of which Mr. Dingell is so quick to accuse those with whom he disagrees. . . .

We note that Mr. Dingell is urging every local Democrat to "put on a telephone campaign" on this matter. This surprised us somewhat, for we have considered the matter of Compulsory Health Insurance much more a matter of public health and welfare than Party politics. As a matter of fact, we have not sought Party endorsements of any kind. Actually, there are probably more Democrats than Republicans among the officers and leaders of the American Medical Association. . . . I myself am a lifelong Democrat. . . .

The President's Page in the October 14 issue of The Journal of the American Medical Association, titled "A Special Message," is a reproduction of Dr. Henderson's memorandum to the members of Congress. Every member of the Florida Medical Association will do well to reflect upon his words—a clarion call which meets the issue squarely.

Florida Fights Tuberculosis Through Cooperative Endeavor

Cooperation is the keystone of the arch of Florida's current success in battling tuberculosis. The Florida State Board of Health, the State Tuberculosis Board and the Florida Tuberculosis and Health Association form a triumvirate which, with such allies as the State Welfare Board, medical societies and the Vocational Rehabilitation Service, is putting Florida well on the way to se-

curing adequate hospital facilities for treating tuberculosis.

Now that only three counties in the state lack local health services and the program of mass x-ray surveys in every county has gained great momentum, the three official cooperating agencies are making excellent progress in accumulating facts and figures which reveal the true picture. Approximately half of the population has been subjected to roentgen examination of the chest by means of the mass x-ray surveys during the last three years, and it is estimated that there are 13,000 tuberculous persons in the state, one fourth of whom are in need of hospitalization.

The rapid finding of hundreds of new cases brought with it the formidable problem of additional hospital facilities. The only adequate sanatorium, completed in 1938 at Orlando, could accommodate but 375 patients. As a temporary measure, army barracks at Marianna in Northwest Florida and Tampa in Southwest Florida, secured from the War Assets Administration in 1946, were renovated and used to hospitalize 1,100 patients. The dedication of the new 508 bed Southeast Florida Tuberculosis Sanatorium at Lantana on July 16 of this year marked a particularly notable achievement. This \$4,500,000 hospital was constructed with federal and state funds on 160 acres of land provided by Palm Beach County. Authorities consider it one of the most beautiful and modern tuberculosis hospitals in the world.

Concerted effort and groundwork well laid led to the appropriation by the 1949 Legislature of \$6,000,000 for new construction. This appropriation will make possible within the next two years the replacement of the temporary facilities at Tampa with a 500 bed hospital similar to the one at Lantana and the building of a 350 bed unit at Tallahassee replacing the temporary facilities at Marianna. The Marianna unit will be renovated and used as a 225 bed convalescent and rehabilitation training center. With the opening of the two new hospitals, Florida will have modern hospital facilities for 1,950 tuberculous patients.

Only one more tuberculosis hospital, to be located in the northeastern section of the state, will then remain to be provided. A model research laboratory costing \$500,000 is also contemplated. Continued close cooperation between all official and voluntary organizations promise to make Florida one of the leading states in the nation in the war against tuberculosis.

Cardiovascular Diseases

With steadily increasing expectation of life, cardiovascular diseases take a heavier toll. They accounted for 33 per cent of mortality in 1935, compared to 44 per cent in 1948. The latter figure represents well over 600,000 persons, a number equal to the population of San Francisco. In that year, these diseases killed more than 54 per cent of the adults who died after the age of 65 and 11 per cent of the children who died between the ages of 5 and 15.

Three times more deadly than cancer, this group took the life of 5 times more people than accidents in 1948, 11 times more than pneumonia and influenza, 14 times more than tuberculosis and 16 times more than diabetes. These figures were presented early this year at the National Conference on Cardiovascular Diseases, where eminent physicians, scientists, other professional workers and laymen discussed the problems of preventing and controlling cardiovascular disease.

Of more than twenty kinds of cardiac disease from which some 9,000,000 people in the United States are suffering, only four are numerically important: congenital heart disease, rheumatic heart disease, arteriosclerosis and related vascular diseases, and hypertension. With the causes of congenital malformations only beginning to be understood, with the origin of rheumatic fever still a mystery, and with the causes of hardening of the arteries and high blood pressure as yet unknown, obviously research must be pressed in these fields.

Meanwhile, a second requisite for further progress is fuller application of existing knowledge. Despite serious gaps in the knowledge of prevention and treatment, the chances for patients with heart disease to lead a useful life are steadily improving. Nevertheless, all professions related to the prevention and treatment of heart disease may well make greater use of the facts that are known today. A major concept that grew out of the conference was that many skills, many professions, must collaborate if present and potential patients are to reap the benefits of contemporary knowledge.

Book for Patients on Heart Disease

What physician does not daily appreciate the need for lay health education? Many doctors have expressed a desire for an authoritative book on heart disease, in particular, written in a style patients could understand. Unquestionably, a goodly

number of the 9,000,000 sufferers from cardiac disorders, mentioned editorially in this issue of *The Journal*, would enjoy better emotional and physical health if they understood a few basic facts.

"You and Your Heart"¹ is a new book on heart and circulatory diseases written for the layman by eminent authorities. To those seeking accurate, helpful and hopeful information about the heart, its function, and the diseases to which it is subject, this book will be most valuable. It is designed to explain many things the busy physician may not have time to explain in his office and to supply exactly what is needed for patients who have, or think they may have, some disease of the heart or blood vessels.

The select group of distinguished authors is composed of: Dr. H. M. Marvin, President, American Heart Association and Associate Clinical Professor of Medicine, Yale University; Dr. Irving S. Wright, President, New York Heart Association and Professor of Clinical Medicine, Cornell University; Dr. Irvine H. Page, Director of Research, Cleveland Clinic Foundation and Chairman of the Medical Advisory Board Council for High Blood Pressure Research of the American Heart Association; Dr. T. Duckett Jones, Medical Director of the Helen Hay Whitney Foundation; and Dr. David D. Rutstein, Professor of Preventive Medicine, Harvard University.

1. Marvin, H. M., and others: *You and Your Heart*, New York, Random House, pages 317, price, \$3.00; also obtainable from the Florida Heart Association, Inc., P. O. Box 587, St. Petersburg 1, Fla.

Florida Welcomes Dr. Sweany

The first medical director of the State Tuberculosis Board, Dr. Henry C. Sweany, recently assumed his duties with headquarters in Jacksonville for the present. The State Tuberculosis Board is to be congratulated on bringing to Florida this eminent authority, formerly director of research and laboratories at the Municipal Tuberculosis Sanatorium in Chicago. He will have charge of administration, medical care and research for the existing hospitals at Orlando, Lantana, Tampa and Marianna. Foremost among his objectives will be completion of the state's present building program and early formation of a research center, mentioned editorially in this issue of *The Journal*.

Dr. Sweany has won international recognition in the field of research. With his knowledge of research needs in tuberculosis, he is exceptionally well qualified to hold his unique post. Realization of the new construction and medical care program

under his able leadership will place Florida in the vanguard of states in the endless quest for the best and most efficient methods of treatment of tuberculosis with the ultimate aim of complete eradication of the disease as a major public health problem.

Medical District Meetings, 1950

The fall meetings in the four medical districts were held in late October and early November. These afternoon and evening meetings offered a splendid opportunity for the members throughout the state to meet their state officers and colleagues and at the same time to hear scientific papers of unusual interest.

Dr. Lloyd J. Netto, Chairman of the Council, was unable to be present because of circumstances over which he had no control. All of the eight councilors were present at their respective district meetings and presided in a most efficient manner. This is an unusual attendance record for councilors as it is very exceptional to have a 100% attendance.

Dr. Herbert E. White, President, after making a few announcements of particular interest, addressed the group on "The Blue Shield," which is the offspring of the Association.

Dr. David R. Murphey, Jr., President-elect, used as the basis of his address, "FMA Grievance Committee."

Dr. Robert B. McIver, Secretary-Treasurer was assigned the subject "Procurement and Assignment." At his own expense, Dr. McIver made a trip to the A.M.A. headquarters in Chicago to obtain the latest information concerning the need for medical officers in military service. A portion of his time was given to Dr. J. Rocher Chappell, Chairman of the Association's Procurement and Assignment Committee. Dr. Chappell stated that his committee met in August at Ponte Vedra and again in Orlando on October 22. At this second meeting, the chairmen of the county medical society Procurement and Assignment Committees were invited to attend. Dr. Chappell reviewed the information that his Committee has received to date.

At the Ocala meeting, Dr. James L. Borland was present as Chairman of the Association's Committee on Emergency Medical Service and Dr. McIver requested him to review the activities of this committee.

Dr. Webster Merritt, Assistant Editor of The Journal gave a brief history of The Journal and Association proceedings from 1874 when the first meeting of the Association was held, to date.

Dr. Joseph S. Stewart, Chairman of the Association's Committee on Public Relations and the State Education Campaign Committee addressed the group at the Fort Myers meeting and at his request, Dr. Walter C. Payne talked on the same subject at the Marianna meeting.

Dr. Eugene G. Peek, Sr., Chairman of the Association's Committee on Legislation and Public Policy outlined the program and procedures formulated by his committee and requested the cooperation of every member as well as the Woman's Auxiliary. Dr. Peek's address was scheduled immediately following the dinner in the evening. This change of schedule at the four medical district meetings proved to be excellent. At this time, the members of the Woman's Auxiliary were present and as they have demonstrated recently, their aid in this particular field has been of unusual value. Mrs. James L. Anderson, President of the State Woman's Auxiliary personally attended the Marianna meeting.

At the West Palm Beach meeting, Representative B. Elliott, Speaker-Designate of the House was a guest at dinner and gave a very interesting and instructive talk.

The registration of doctors, guests and members of the Woman's Auxiliary at the four medical district meetings totaled 330.

Northwest Medical District — A October 30 — Marianna

Dr. Arthur J. Butt, Jr., councilor of district 1, and Dr. Taylor W. Griffin, councilor of district 2, presided at the meeting which was held in the Community House.

Dr. James T. Cook, president of the Jackson County Medical Society, welcomed the members and guests as the meeting opened at 2:30 p.m.

Immediately following, Dr. Francis M. Watson of Marianna, a member of the district, spoke on "Atomic Radiation Delivered by the Bomb." Dr. Arthur J. Wallace, Jr., of Tampa, the guest speaker, chose for his subject, "Benign and Malignant Lesions of the Vulva." A general discussion followed the reading of the papers.

Pensacola was selected at the general session for the meeting place in 1951.

Officers of the State Association presented short talks on matters of concern to all members of the Association.

Refreshments and dinner were served by the host society.

The total registration was 74, of which 42 were Association members (from A District, 33), 15 visitors and 17 Woman's Auxiliary members. State Association officers present were: Herbert E. White, president; David R. Murphey, Jr., president-elect; Robert B. McIver, secretary-treasurer; Eugene G. Peek, Sr., chairman of the Legislation and Public Policy Committee; Stewart G. Thompson, managing director; Arthur J. Butt, Jr., councilor of District 1 and Taylor W. Griffin, councilor of District 2.

Registration

ALFORD: Cleveland J. Price. ALTHA: Jasper B. Dowling. APALACHICOLA: Terry Bird. CHATTAHOOCHEE: John T. Benbow, Walter C. Miles, Harold H. Ring, William D. Rogers. GRACEVILLE: Redden L. Miller. GRAND RIDGE: Charles H. Ryals. JACKSONVILLE: Robert B. McIver, Webster Merritt, Frances E. M. Read, Stewart G. Thompson. MARIANNA: Jabe A. Breland, James T. Cook, Daniel A. McKinnon, Albert E. McQuagge, Elmer J. Teagarden, William R. Wandek, Francis M. Watson, Courtland D. Whitaker. Ocala: Eugene G. Peek, Sr. ORLANDO: J. Rocher Chappell. PANAMA CITY: William C. Roberts, C. W. Shackelford. PENSACOLA: Egbert V. Anderson, Herbert L. Bryans, Arthur J. Butt, Jr., Samuel G. Holmes, Alpheus T. Kennedy, John C. McSweeney, Jr., Walter C. Payne. QUINCY: Taylor W. Griffin, Edward C. Love, Jr., George H. Massey. ST. AUGUSTINE: Herbert E. White. TALLAHASSEE: Merritt R. Clements, Paul J. Coughlin, Robert H. Mickler, Henry L. Smith, Jr. TAMPA: David R. Murphey, Jr., Arthur J. Wallace, Jr.

VISITING DOCTORS—CHATTAHOOCHEE: Oswald A. Holzer. JACKSONVILLE: William M. Hanrahan, Knox E. Miller. MARIANNA: Arlo K. Cox, J. E. Harris, A. A. Kartsonis, Lawrence C. Manni. PANAMA CITY: Daniel C. Campbell, William F. Humphreys, Jr., Harold E. Wager. ST. ANDREW: Sidney E. Daffin.

ALABAMA—DOTHAN: Wyatt T. Burkett, Percy I. Hopkins. COTTONWOOD: Dorman M. Hicks.

OTHER GUESTS—JACKSONVILLE: Mr. Wm. Harold Parham.

Northeast Medical District — B November 1 — Ocala

The meeting was held at the Elks Club with Dr. Eugene G. Peek, Jr., councilor of district 3, and Dr. Cleland D. Cochrane, councilor of district 4, presiding.

At 2:30 p.m., members and guests were welcomed by Dr. Richard C. Cumming, president of the Marion County Medical Society.

The scientific program was opened by Dr. John P. Michaels of Orlando, district member, who presented a paper on "The Cervical Stump — Necessary Evil?" Dr. Sidney Davidson of Lake Worth, guest speaker, presented a paper on "The Insulins and Their Use." The floor was opened for discussion of the papers.

At the general session, Orlando was selected as the meeting place for 1951.

The chairman called on the officers of the State Association who responded with short talks of statewide interest.

Refreshments and dinner were served by the host society.

The total registration was 112, of which 85 were Association members (from B District, 79), 6 visitors and 27 Woman's Auxiliary members. State Association officers present were: Herbert E. White, president; David R. Murphey, Jr., president-elect; Robert B. McIver, secretary-treasurer; Eugene G. Peek, Sr., chairman of the Legislation and Public Policy Committee; Stewart G. Thompson, managing director; Eugene G. Peek, Jr., councilor of District 3 and Cleland D. Cochrane, councilor of District 4.

Registration

BROOKSVILLE: George R. Creekmore. COCOA: A. F. Thomas. CRESCENT CITY: James W. Davidson. CRYSTAL RIVER: William B. Moon. DAYTONA BEACH: James W. Clower, Jr., Cleland D. Cochrane, C. Robert DeArmas, Peter A. Drohomer, David W. Goddard, Herbert A. King, James D. Moffett, Jr., Ellsworth F. Waite, Norman E. Williams. EUSTIS: Rabun H. Williams. HOLLY HILL: Frank A. Sica. GAINESVILLE: Edwin H. Andrews, Thomas M. Brill, James M. McClamrock, John E. Maines, Jr., George H. Putnam, Winston L. Summerlin, William C. Thomas, Jr. JACKSONVILLE: James L. Borland, Frederick H. Bowen, Turner Z. Cason, James V. Freeman, Lawrence E. Geslin, Karl B. Hanson, F. Gordon King, James G. Lyerly, Robert B. McIver, Webster Merritt, Nelson A. Murray, Frances E. M. Read, Lauren M. Sompayrac, Walker Stamps, Stewart G. Thompson, Albert H. Wilkinson, Ashbel C. Williams. LAKE CITY: Robert B. Harkness. LAKE WORTH: Sidney Davidson. LEESBURG: Leroy H. Oetjen, Marion B. O'Kelley. Ocala: William H. Anderson, Jr., Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, John D. Lindner, Carl S. Lytle, William J. McGovern, John N. Moore, John P. Moore, Robbins Nettles, Eugene G. Peek, Sr., Eugene G. Peek, Jr., Robert E. Thompson, Jack M. Waldrep, Harry F. Watt. ORLANDO: J. Rocher Chappell, Chas. J. Collins, Russell V. Douglas, David Y. Hicks, Gerald W. Jones, Duncan T. McEwan, John P. Michaels, Robert G. Neill, Robert E. Zellner. ST. AUGUSTINE: Reddin Britt, A. Clark Walkup, Herbert E. White. SANFORD: Thomas F. McDaniel, Harry Z. Silsby, George H. Starke (Col.). TAMPA: Samuel G. Hibbs, David R. Murphey, Jr. TAVARES: James R. Hanson. WILDWOOD: Herbert M. Webb, Jr. WINTER GARDEN: Albert H. Gleason.

VISITING DOCTORS—GAINESVILLE: Everett E. Howard, Charles J. Zinn. JACKSONVILLE: William M. Hanrahan, Knox E. Miller.

OTHER GUESTS—DAYTONA BEACH: Mr. T. F. Little. JACKSONVILLE: Mr. Wm. Harold Parham.

Southwest Medical District — C November 2 — Ft. Myers

The meeting was held at the Franklin Arms Hotel with Dr. M. Crego Smith, councilor of district 5, and Leldon W. Martin, councilor of district 6, as presiding officers.

Dr. Walter B. Clement, president of the Lee-Charlotte-Collier-Hendry County Medical Society, welcomed the members and guests.

"The Management of Hemangiomas" was chosen by district member, Dr. Wesley W. Wilson of Tampa, as the initial paper of the scientific program. Dr. S. Ward Fleming, guest speaker from West Palm Beach, spoke on "Surgical Treatment of Benign and Malignant Lesions of Stomach." Interesting discussions followed.

At the general session, Bradenton-Sarasota was selected as the meeting place for 1951.

The chairman called on the officers of the State Association who responded with addresses of statewide interest.

Refreshments and dinner were served by the host societies.

The total registration was 80, of which 49 were Association members (from C District, 40), 4 visitors and 27 Woman's Auxiliary members. State Association officers present were: Herbert E. White, president; David R. Murphey, Jr., president-elect; Robert B. McIver, secretary-treasurer; Eugene G. Peek, Sr., chairman of the Legislation and Public Policy Committee; Joseph S. Stewart, chairman of the Public Relations Committee; Stewart G. Thompson, managing director; M. Crego Smith, councilor of District 5 and Leldon W. Martin, councilor of District 6.

Registration

ARCADIA: Harold S. Agnew, Gordon H. McSwain, John A. Simmons. BRADENTON: William D. Sugg. CLEARWATER: William G. Mason, M. Crego Smith. DUNEDIN: Walter H. Winchester. FORT MYERS: Fred D. Bartleson, Ernest Bostelman, Joseph D. Brown, A. Louis Girardin, Jr., William H. Grace, Warren A. Harrison, Curtis R. House, Marion F. Johnson, C. Gordon Merrick, Joseph L. Selden, Jr., John C. Vinson, Baker Whisnant. JACKSONVILLE: Robert B. McIver, Webster Merritt, Frances E. M. Read, Stewart G. Thompson. LAKE LAND: William M. Bevis. MIAMI: Joseph S. Stewart. NAPLES: James A. Craig. OCALA: Eugene G. Peek, Sr. ORLANDO: J. Rocher Chappell. PUNTA GORDA: Walter B. Clement, Roscoe S. Maxwell. ST. AUGUSTINE: Herbert E. White. ST. PETERSBURG: Abraham J. Gorday, James L. Gouaux. SARASOTA: Michael A. DiCosola, Henry G. Morton, Melvin M. Simmons, Reaves A. Wilson. SEBRING: Leldon W. Martin, Howard V. Weems, Sr. TAMPA: Chadbourne A. Andrews, Ernest R. Bourkard, J. Robert Campbell, Herschel G. Cole, Charles McC. Gray, David R. Murphey, Jr., James N. Patterson, Elbert J. Soskis, Wesley W. Wilson. WEST PALM BEACH: S. Ward Fleming.

VISITING DOCTORS—CLEARWATER: Francis C. Hoare. JACKSONVILLE: William M. Hanrahan, Knox E. Miller.

OTHER GUESTS—JACKSONVILLE: Mr. Wm. Harold Parham.

Southeast Medical District — D November 3 — West Palm Beach

Dr. Adrian M. Sample, councilor of district 7, and Dr. S. Marion Salley, councilor of district 8, presided at the meeting which was held at the Biltmore Hotel.

Dr. Charles McD. Harris, Jr., president of the Palm Beach County Medical Society, welcomed the members and guests.

Dr. Fred E. Manulis of Palm Beach, a member of the district, opened the scientific program with his paper on "Management of Massive Hemorrhage from the Upper Gastro-Intestinal Tract." Dr. John H. Nodine of Bradenton was scheduled to give a paper on "Infertility in General Practice." Because Dr. Nodine has recently been called into military service, his paper was read by Dr. Dorothy Speers of Titusville.

At the general session, Vero Beach was designated as the meeting place for 1951.

The chairman called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments and dinner were served by the host society.

The total registration was 64, of which 46 were Association members (from D District, 36), 8 visitors and 10 Woman's Auxiliary members. State Association officers present were: Herbert E. White, president; David R. Murphey, Jr., president-elect; Robert B. McIver, secretary-treasurer; Eugene G. Peek, Sr., chairman of the Legislation and Public Policy Committee; Stewart G. Thompson, managing director; Adrian M. Sample, councilor of District 7 and S. Marion Salley, councilor of District 8.

Registration

BOYNTON: Nathaniel M. Weems. CORAL GABLES: T. D. Sandberg. DANIA: Fred E. Brammer. DELRAY BEACH: Charles A. Robinson. FORT LAUDERDALE: Russell B. Carson, Anne L. Hendricks, Wilks O. Hiatt, Jr., Leigh F. Robinson, Curtis H. Sory. FORT PIERCE: Adrian M. Sample, Richard F. Sinnott. JACKSONVILLE: Robert B. McIver, Webster Merritt, Frances E. M. Read, Stewart G. Thompson. LAKE WORTH: A. Scott Turk. MIAMI: Francis W. Glenn, S. Marion Salley. OCALA: Eugene G. Peek, Sr. OKEECHOBEE: Leon S. Eisenman. ORLANDO: J. Rocher Chappell. PALM BEACH: George M. Dawson, Russell D. D. Hoover, Fred E. Manulis, Alvin E. Murphy. ST. AUGUSTINE: Herbert E. White. TAMPA: David R. Murphey, Jr. TITUSVILLE: Dorothy J. Speers, James F. Speers. WEST PALM BEACH: John F. Chapman, Victor Clarholm, Gerald M. DeWoody, S. Ward Fleming, Charles McD. Harris, Jr., Frederick K. Herpel, V. Marklin Johnson, Oliver L. Jones, Kenneth E. Montgomery, Theodore Norley, S. Richard Ombres, Ralph M. Overstreet, Jr., Cecil M. Peek, Murray D. Sigman, James R. Sory, Jacob Toporoff, William H. Weems.

VISITING DOCTORS—FORT LAUDERDALE: Vincent V. Smith. JACKSONVILLE: William M. Hanrahan. MIAMI SPRINGS: Joseph R. Morrow. PALM BEACH: Joseph R. West. WEST PALM BEACH: Robert V. Artola, Joseph J. Daversa.

OTHER GUESTS—JACKSONVILLE: Mr. Wm. Harold Parham. PAHOKEE: Mr. B. Elliott.

STATE BOARD OF HEALTH

Hookworm Problem in Florida

Many persons are prone to view the subject of intestinal parasites as somewhat humorous, but the old familiar "worms" are still with us. Quantities of questionable vermifuges are sold over drugstore counters every day. Studies made by the State Board of Health show that an appreciable percentage of the people of Florida today have some type of intestinal parasitic infection. True, the worm burden is much lighter than it was ten years ago, but the generally accepted opinion is that the presence of any number of hookworms, for example, is prejudicial to optimum health.

It is not enough to think that since a child lives in an urban area and in a section of the state where hookworm does not thrive that, therefore, he is not infected. Our nomadic population and summer vacations spent in rural areas, especially in sections known to have a higher rate of infection than other parts of the state, make many of us suspect. *Ascaris* is frequently found in the Negro, but hookworms are more widespread generally and involve white persons more than Negroes.

The old popular notion that it was sufficient to examine a child, treat him if parasites were present and then bid him goodbye no longer exists. Private physicians as well as public health personnel want to know how the child contracted the disease, for he will contract it again if the home sanitary facilities are such that hookworms breed and are transmitted easily. Assistance in planning for better home sanitation is one of the duties of the Health Officer and his staff.

Physicians Employed by the State Board of Health and County Health Departments

The State Board of Health and its affiliated county health departments now employs about 60 full time physicians. From time to time comment is heard among the practicing physicians of the state to the effect that such employment is used as a portal of entry into the private practice of medicine in Florida. The facts do not bear this out. Since the appointment of the present State Health Officer on September 15, 1945, 129 physicians have been employed. Of these only 14 have entered private practice in the state although 68 have left the service of the State Board of Health. The vast majority of these had Florida licenses and

could have entered practice here had they chosen to do so. The insignificance of this problem to private physicians is evident when we consider that during this same five year period a total of 1616 physicians have been licensed by the State Board of Medical Examiners.

Criticism is also heard of the fact that some physician employees of the State Board of Health do not have their licenses. It has been impossible to recruit physicians from within the State of Florida for public health positions and practically all of the 99 physicians recruited during the five year period were from outside of the State of Florida. These physicians have obtained their Florida licenses as soon as possible and all physicians who have been employed by the State Board of Health for more than two years are licensed. Most of them as a matter of fact get their licenses in a much shorter period. Unless a reasonable time is allowed to obtain such licenses the State Board of Health could not carry on its work. The cooperation of the medical profession of the state and of the State Board of Medical Examiners in connection with this problem is very much appreciated.

Diabetes Program

The diabetes control program of the State Board of Health is directed by the Division of Nutrition and Diabetes Control. It has three major parts, namely: distribution of insulin to indigent diabetics, mass screening for early case finding, and education of the diabetic and the public.

Distribution of insulin to indigent diabetics is carried out through county health departments. The person receiving this insulin is certified by the county health officer as being unable to purchase insulin. Advice on this is secured from the local welfare agent and from the physician in charge of the case. Patients are also required to see a physician once every three months for review of their case and renewal of the insulin prescription. This service has been carried out by the State Board of Health since 1935.

Mass screening for diabetes is carried out through the county health departments with the State furnishing technical personnel and services. To date the State Board of Health, in cooperation with other public health agencies, has screened 22,490 persons in the State, of which 322 have been found to have blood sugar values indicative of diabetes. Screening surveys are carried out only in those counties where the local medical society has

approved the procedures. All persons screened are referred to the physician of their choice for diagnosis and treatment.

Education of diabetics is done also through the county health departments with the State Board of Health furnishing consultation and materials. There is available a monthly newsletter to diabetics known as "Timely Topics" which will be sent to any citizen of Florida whose physician certifies him as being a diabetic and requests that his patient be given this service. Demonstration classes for diabetics are held by State Board of Health personnel with a view to a permanent local program being carried on by the county health departments.

Materials furnished through county health departments to physicians include a meal planning booklet,* prepared by the American Diabetic Association, the American Dietetic Association and the United States Public Health Service, State Board of Health pamphlets on insulin injection and urine testing, and film strips on various technics a diabetic must learn in order to follow his doctor's orders.

Education of the public is assisted by means of technical personnel, pamphlets and films. This program is intended to be in cooperation with the physician in the drive to bring the one million undiscovered diabetics in the United States under medical care and to furnish assistance in bringing to them the benefit of modern treatment.

**The ADA Meal Planning Booklet is furnished for indigent diabetics only.*

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Beach, William C., St. Petersburg
Bone, Frank C., Orlando
Breland, Jabe A., Marianna
Broome, Robert A., Jr., Orlando
Erwin, Charles R., Winter Haven
Greenfield, Maurice M., Miami
Jahn, Paul H., Winter Haven
Jana, Joseph T., Jr., Miami
Knight, Frederick C., St. Petersburg
Maxon, Robert von P., Fort Walton
Stern, Henry M., Lakeland

STATE NEWS ITEMS

Annual dues of the Association beginning January 1, 1951 will be \$40.00 per capita. This assessment was established by the House of Delegates at Hollywood, April 26, 1950. Included in this amount is the subscription for The Journal.

Any new member accepted in the Florida Medical Association shall be required to pay a \$10.00 entrance fee. The reinstatement entrance fee for a member* who is reinstated after having been dropped from the roster shall be the same amount as the current annual dues in addition to his first dues.

*(*When dues remain unpaid for more than one calendar year an applicant's status will be that of a new member with entrance fee of \$10.)*

All Association dues and fees must be paid to the secretaries of county medical societies. The By-Laws of the Association require that each county society secretary shall forward the Association dues for his members to the secretary of the Florida Medical Association on or before February 1.

Early last month Dr. Louis M. Orr II of Orlando was among the distinguished guest speakers invited into the state of Tennessee as a faculty to further its Cancer Instruction program. In East Tennessee five centers were established, with the cooperation of local medical societies and groups, where postgraduate instruction in cancer was presented. This program, sponsored jointly by the Tennessee State Medical Association (Postgraduate Committee) and the Tennessee Division of the American Cancer Society, was initiated last May when a cancer team, of which Dr. Orr was a member, offered instruction in five centers in West Tennessee. Presentation in these ten centers, located geographically within reach of all the profession, proved a unique and highly satisfactory method of providing graduate instruction in cancer, Dr. Orr reported.

Dr. Shaler Richardson of Jacksonville has returned to his practice following visits to clinics and medical meetings in New York City and vicinity.

Dr. Warren W. Quillian of Coral Gables is the new president-elect of the American Academy of Pediatrics.

The following Association members registered at the meeting of the American Academy of Pediatrics which was held in Chicago in October: Drs. Warren W. Quillian and Hillard W. Willis, Coral Gables; Robert R. Harriess, Hollywood; Cornelia M. and Hugh A. Carithers, Jacksonville; James R. Boulware, Jr., and Fred S. Gachet, Lakeland; Wesley S. Nock, Miami; Meyer B. Marks and Elias Freidus, Miami Beach; Ralph E. Baxter, Miami Shores; George W. Griffin and John D. McKey, Orlando; Councill C. Rudolph, St. Petersburg; Henry G. Morton, Sarasota; Ernest W. Ekermeier, Tallahassee; Leo Batell, Tampa, and Lawrence R. Leviton, West Palm Beach.

Dr. Robert B. McIver of Jacksonville, secretary-treasurer of the Association, recently spent several days in Chicago conferring with A.M.A. officials relative to problems affecting the state association and the county medical societies.

Dr. Samuel G. Hibbs of Tampa was the guest speaker at the October meeting of the Woman's Auxiliary to the Hillsborough County Medical Association.

Dr. Richard C. Cumming of Ocala recently addressed the local Kiwanis Club on the subject of "Music and Medicine." Dr. Cumming sang a number of songs as examples of the type of music which he believes to have therapeutic value in cases of nervous fatigue.

Dr. James L. Borland of Jacksonville was the guest speaker at the October meeting of the Marion County Medical Society. Dr. Borland used lantern slides to illustrate his topic of "Infectious Hepatitis."

Dr. Samuel G. Hibbs of Tampa was the guest speaker at the Ybor City Rotary Club meeting held recently in the Columbia Restaurant. His topic was mental hygiene.

At the recent meeting of the Florida Division, American Cancer Society in St. Petersburg, Drs. Frederick K. Herpel and Vale D. Stone, both of West Palm Beach, were re-elected to the Board of Directors. Dr. Lorenzo L. Parks of Jacksonville was the Florida Division's medical delegate to the national convention which was held in New York City, October 26-27.

Dr. Carlos P. Lamar, recently elected president of the Miami Diabetes Association, has been notified of his appointment to the editorial board of an American Diabetic Association publication which is designed for the use of the diabetic patient and other laymen.

Assisting Dr. Lamar in the Dade County Diabetes Detection Drive for 1950 are Drs. Milton S. Belle, Otto W. Burtner and Jack Q. Cleveland.

Dr. Eugene G. Peek, Sr., of Ocala, chairman of the Association's Committee on Legislation and Public Policy, and Dr. H. Phillip Hampton of Tampa, member of the committee, represented the Florida Medical Association in a conference held at the Academy of Medicine in Atlanta on October 26. Also present from Florida were Dr. Stewart G. Thompson, managing director, and W. Harold Parham, supervisor of the Bureau of Public Relations.

This conference was one of a series of district meetings sponsored by the A.M.A. legislative committee, and the arrangements were made by Dr. Julian P. Price of Florence, South Carolina, A.M.A. legislative committee member from the southeast district.

The program for the all-day conference was under the direction of Dr. Joseph S. Lawrence, director of the Washington office of the A.M.A.

Dr. Wilbur C. Sumner of Jacksonville has returned to his practice following a study course in the recent advances in cardiac surgery at Johns Hopkins Hospital.

Dr. R. Wynn S. Owen of St. Petersburg recently returned from a visit to surgical clinics at the Lahey Clinic, Boston, Crile Clinic, Cleveland, and the Indiana University School of Medicine.

Dr. George H. Putnam of Gainesville has returned to his practice following his attendance at a postgraduate urological seminar at the University of Louisville School of Medicine.

Dr. Arthur J. Butt, Jr., of Pensacola was the guest speaker at the third annual fellows meeting at the Alton Ochsner Medical Foundation recently held at the Foundation Hospital in New Orleans. His subject was "The Role of Urinary Colloids in the Prevention of Renal Calculi."

Dr. J. Rocher Chappell of Orlando, chairman of the F.M.A. Procurement and Assignment Committee, called a meeting of this committee in Orlando Sunday, October 15. Other members of the F.M.A. committee present were Drs. Thomas H. Bates, Lake City; John E. Maines, Jr., Gainesville, and Donald W. Smith, Miami. Present from the Association's headquarters office in Jacksonville were Dr. Stewart G. Thompson, Ernest R. Gibson and W. Harold Parham.

Problems of the procurement and assignment of medical officers and interpretation of the recently enacted doctor-draft legislation were discussed by the committee and representatives of procurement and assignment committees of various county medical societies. Representing the county medical societies were the following:

BAY: Amsie H. Lisenby, Panama City. BREVARD: Walter C. Page, Cocoa. DADE: Milton S. Saslaw. DESOTO-HARDEE-HIGHLANDS-GLADES: Henry P. Bevis, Arcadia. DUVAL: John F. Lovejoy, Jacksonville. INDIAN RIVER: Erasmus B. Hardee, Vero Beach. LAKE: Sanford C. Colley, Mount Dora, Howard G. Holland, Leesburg, and C. McK. Tyre, Eustis. LEE-CHARLOTTE-COLLIER-HENDRY: Morris J. Alexander, Punta Gorda. MANATEE: William D. Sugg, Bradenton. ORANGE: Robert P. Henderson, Orlando. PALM BEACH: Frederick K. Herpel, West Palm Beach. PINELLAS: R. Wynn S. Owen and John P. Rowell, St. Petersburg. POLK: T. Hugh Roberts, Lakeland. ST. LUCIE-OKEECHOBEE-MARTIN: Julian D. Parker, Stuart. SARASOTA: Hugh G. Reaves, Sarasota. SEMINOLE: Charles L. Park, Sanford. VOLUSIA: Robert L. Miller, Morris B. Seltzer and Hugh West, Daytona Beach.

A question and answer period on selective service regulations as they apply to medical and allied personnel was led by Col. W. Gentry White of St. Augustine, deputy director of Selective Service, and Lt. Col. Harold Wahl of St. Augustine, who is in charge of manpower for the state of Florida. Both officers were representing General Vivian Collins, director of Selective Service.

Immediately preceding the meeting of the F.M.A. Procurement and Assignment Committee, there was a meeting of the Florida Voluntary Advisory Board for the procurement and assignment of medical, dental and veterinary officers. Dr. J. Rocher Chappell is chairman of this committee also. Other members are Wilson T. Sowder, M.D., Jacksonville, and Fred O. Conrad, D.D.S., Tallahassee. Representing other groups were Alvin J. Fillastre, D.D.S., Lakeland, president of the Florida State Dental Society; Thomas Price, D.D.S., Miami, Dade County Dental Screening Committee; T. H. Applewhite, D.V.M., Jacksonville, and D. A. Sanders, D.V.M., Gainesville, both from the Florida State Veterinary Medical Association.

Dr. Herman K. Moore of Key West recently returned to his practice following a short postgraduate course in electrocardiography at the University of Michigan Medical School.

Dr. Mark E. Adams of Jacksonville attended a Short Course on Endocrinology which was conducted by the University of Georgia School of Medicine in Augusta in September.

Dr. Allen S. Shepard of Key West has returned to his practice following a postgraduate course in pediatrics at New York Medical College.

Dr. William D. Rogers, staff member of the Florida State Hospital at Chattahoochee for sixteen years, has been named superintendent of that institution. Dr. Rogers succeeds the late Dr. J. H. Therrell.

Drs. Luverne H. Domeier and Charles K. Donegan of St. Petersburg were guest speakers at the recent meeting of the Society of American Medical Technologists which was held in the Suwannee Hotel, October 29.

Dr. Donald M. Baldwin of Jacksonville was guest speaker at the October meeting of the Columbia County Medical Society.

Dr. Clarence M. Sharp of Jacksonville has been elected to the executive council of the Southern Tuberculosis Conference.

FOR SALE: Practically new, Complete Mattern X-Ray and Diathermy machine. No reasonable offer refused. Contact City of Waldo, Waldo, Florida.

WANTED: General Practitioner for small town and lake area. Free rent on new office including some equipment. Should gross \$20,000-\$30,000. Former doctor called into Army. Contact Mayor B. A. Beville, Waldo, Florida.

RADIOLOGIST SEEKS ASSOCIATION: With Hospital, Group, or other Radiologist. Board Diplomate, Diagnosis and Therapy. Age 35. American, Cornell Graduate, healthy, hard worker. Florida license. Write 69-33, P. O. Box 1018, Jacksonville, Fla.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Joseph J. Lowenthal of Jacksonville announce the birth of a daughter on Oct. 2, 1950.

Dr. and Mrs. Lawrence E. Geeslin of Jacksonville announce the birth of a son on Oct. 4, 1950.

Dr. and Mrs. Willard R. Gatling of Jacksonville announce the birth of a son, Robert Stevens, on Oct. 13, 1950.

Dr. and Mrs. Charles F. McCrory of Jacksonville announce the birth of a son, James Hollis, on Oct. 15, 1950.

Dr. and Mrs. Samuel M. Day, Jr., of Jacksonville announce the birth of a son, Samuel Mason, III, on Oct. 21, 1950.

Marriages

Dr. Joseph Q. Perry and Miss Shirley Katherine Anderson, both of Pensacola, were married on Oct. 20, 1950.

Deaths - Members

Anderson, Warren E., Pensacola	Aug. 21, 1950
Messner, Paul O., Miami Springs	Oct. 2, 1950
Massey, Wm. W., Quincy	Oct. 4, 1950
Vallotton, J. Ralph, Daytona Beach	Oct. 6, 1950
Beals, John A., Jacksonville	Nov. 11, 1950

Deaths - Other Doctors

Ford, James A., Orlando	Sept. 23, 1950
Middlebrooks, Violet C., St. Petersburg	Oct. 5, 1950
McKnight, George S., Avon Park	Oct. 10, 1950
Potthoff, Ernest W., Titusville	Oct. 12, 1950
Kutscher, Charles F., Pittsburgh, Pa.	Recently

COMPONENT SOCIETY NOTES

Alachua

All members of the Alachua County Medical Society have paid 1950 state dues.

Dade

The Dade County Medical Association held its regular meeting on November 7, at 8:30 p.m., in the Miami Woman's Club. Heading the program was a talk on voluntary health insurance by Mr. H. A. Schroder, executive director of the Florida Medical Service Corporation and the Florida Hospital Service Corporation. Mr. Schroder's subject was "Blue Cross Protects the People — Who Will Protect Blue Cross?"

On the scientific program Dr. Paul S. Roland gave an illustrated lecture on "Surgery in the Bataan Campaign."

Duval

The Duval County Medical Society held its regular monthly meeting Tuesday, November 7, in the Sellers Auditorium, Jacksonville. Guest speaker was Dr. Charles R. Scott, who addressed the members on "Medico-Legal Problems in Present Day Practice." In addition a motion picture was shown on the subject, "Physiology of Anoxia."

Hillsborough - Pinellas

The Hillsborough and Pinellas county medical societies held a joint meeting in October to hear Dr. Clifford D. Benson, assistant professor of surgery at Wayne University College of Medicine in Detroit.

The two societies met at the Suwannee Hotel in St. Petersburg on November 9 to hear Dr. Homer L. Pearson of Miami.

Lee - Charlotte - Collier - Hendry

The regular monthly meeting of the Lee-Charlotte-Collier-Hendry County Medical Society was held on Monday night, October 16. Members present were Drs. Chester M. Askue, Fred D. Bartleson, Ernest Bostelman, Joseph D. Brown, Angus D. Grace, William H. Grace, Curtis R. House, Marion F. Johnson, H. Quillian Jones, C. Gordon Merrick and Joseph L. Selden, all of Fort Myers. Guests present were Dr. Reidar Trygstad of Naples and Burt Culwell, superintendent of Lee Memorial Hospital.

Marion

The Marion County Medical Society met for its regular October meeting at the 1890 House in Ocala. Guest Speaker was Dr. James L. Borland of Jacksonville who gave an illustrated talk on "Infectious Hepatitis."

The following members were present: Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, Bertrand F. Drake, Eaton G. Lindner, John D. Lindner, Carl S. Lytle, William J. McGovern, Robbins Nettles, Eugene G. Peek, Sr., Eugene G. Peek, Jr., E. Laurence Scott and Jack M. Waldrep, all of Ocala, and Dr. Matthew Arnow of Williston. Dr. Borland and Dr. L. A. Brendle, director of the health unit, were guests.

Palm Beach

All state dues for 1950 have been paid by members of the Palm Beach County Medical Society.

Pinellas

The Pinellas County Medical Society, at its October meeting, installed Dr. Claude B. Wright of St. Petersburg as president. Dr. John P. Rowell of St. Petersburg is the president-elect. Other officers of the society are Dr. Rowland E. Wood, St. Petersburg, first vice president; V. Leroy Hagan, Clearwater, second vice president, and Dr. Whitman C. McConnell of St. Petersburg was re-elected secretary-treasurer.

(Continued on page 383)



"A high percentage of cases of seasickness and carsickness can be aborted or prevented by suitable doses of dimenhydrinate (Dramamine)."

—Council on Pharmacy and Chemistry, New and Nonofficial Remedies, J.A.M.A. 143:815 (July 1) 1950.



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REPRESENT EACH OF THE MANY CONDITIONS FOR
WHICH SHORT-ACTING NEMBUTAL IS EFFECTIVE

THERE'D be at least 44 on hand, Doctor, for that's how many clinical uses for short-acting NEMBUTAL have been reported in the literature. No matter what degree of cerebral depression you desire—from mild sedation to deep hypnosis—you can achieve it with short-acting NEMBUTAL. Dosage required is small, only about *one-half* that of many other barbiturates. Small dosage means less drug to be inactivated, shorter effect, wider margin of safety and less possibility of "hangover."

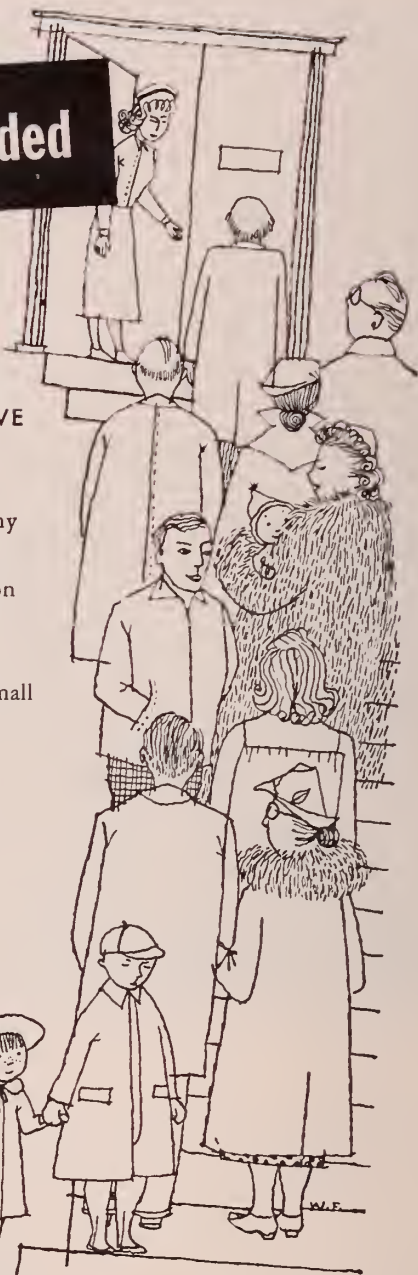
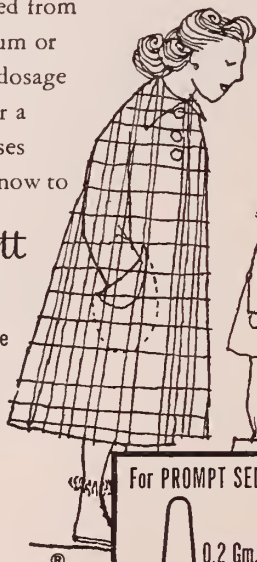
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In equal oral doses, no other barbiturate combines QUICKER, BRIEFER, MORE PROFOUND EFFECT.

NOTE THE NAME

Nembutal

(PENTOBARBITAL, ABBOTT)



For PROMPT SEDATION when the oral route is not feasible...



0.2 Gm.



0.12 Gm.



60 mg.



30 mg.

... try NEMBUTAL SODIUM SUPPOSITORIES

At the regular November meeting of the society, guest speaker, Dr. Arthur Appleyard, discussed, "Severe Reaction to Penicillin Treated Successfully with ACTH."

Sarasota - Manatee

The Sarasota and Manatee County Medical Societies joined in a special meeting on October 4 to hear a number of guest speakers. Cooperating with the two societies were the Sarasota county health department, the Florida State Board of Health and the Nemours Foundation of Wilmington, Delaware.

Guest speakers were Dr. Douglas T. Davidson, Harvard University, Boston, Mass., Dr. David Wade, psychiatrist, Texas Education Agency, Austin, Tex., Dr. A. R. Shands, Jr., medical director of the Nemours Foundation, and Dr. Frances E. M. Read, head of the maternal and child health bureau and director of the mental health program of the Florida State Board of Health.

OBITUARIES

Samuel Royall Norris

Dr. Samuel R. Norris, a resident of Jacksonville for nearly forty years, died there on Sept. 21, 1950 following a long illness. He was 53 years of age.

Born in Raleigh, N. C., on Feb. 7, 1897, Dr. Norris came to Jacksonville in 1911. He was graduated from the old Duval High School in 1914. After receiving the degree of Bachelor of Science from the University of North Carolina in 1920, he was awarded the degree of Doctor of Medicine in 1922 from the University of Pennsylvania School of Medicine. His education was interrupted by World War I, in which he served as a naval aviation pilot from 1917 to 1919. After interning at Howard and Presbyterian hospitals in Philadelphia, he received special training at the Sloan Maternity, Bellevue and Woman's hospitals in New York City.

Dr. Norris entered the private practice of medicine in Jacksonville in 1923. Since 1924 he had served as chief of obstetrics at St. Luke's Hospital and was also chief of obstetrics at Riverside Hospital and the Duval Medical Center. For years he had served as obstetrician for the Volunteers of America and was one of the founders locally of the Visiting Nurses Association.

(Continued on page 384)



From where I sit by Joe Marsh

Here's An "Expert" Example!

When our Main Street parking problem cropped up, we announced a strict one-hour parking policy, and swore in extra deputies to enforce it.

We also sent over to the State Capitol for a traffic expert, to give us pointers. He turned out to be real helpful—spent an afternoon with us talking about zoning and such. And when he left the building he found a ticket on his car for overtime parking!

Could have gotten sore, I guess—or asked us to "fix" the ticket for him. But instead, he insisted on going over to the Sheriff's Office and paying his fine then and there.

From where I sit, it's good to know people, like that young fellow, who refuse to be treated any different than anyone else. City people and farmers—those of us who prefer cider and those who'd rather have a cool glass of temperate beer—we're all entitled to the same privileges. That is, so long as what we do doesn't conflict with the law of the land.

Joe Marsh

simplify the
mother's
problem

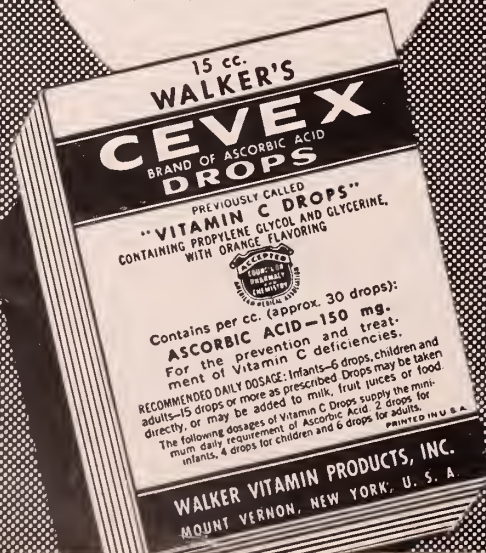
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Each drop supplies 5 mg.
of vitamin C.

CEVEX may be added to
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that is Council accepted
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A member and past president of the Duval County Medical Society, Dr. Norris was also a member of the Florida Medical Association, serving as chairman of its Committee on Maternal Welfare in 1946. In addition, he held membership in the American Medical Association and the Southern Medical Association. He was a past president of the South Atlantic Association of Obstetricians and Gynecologists, a diplomate of the American Board of Obstetrics and Gynecology, a member and on the executive board of the Florida Association of Obstetricians and Gynecologists, a member of the board of directors of the Jacksonville Association of Obstetricians and Gynecologists, and a member of the Southern Interurban Association of Obstetricians and Gynecologists. A fellow of the American College of Surgeons, he was also a member of the International Academy of Medicine and Dentistry.

Surviving are his widow, Mrs. Waldo Latham Norris; his mother, Mrs. Samuel Basil Norris; a stepson, Charles Randolph Unsworth of Dallas, Tex.; and four brothers, Frank, William, Delmar and John Norris.

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1 YEAR \$3.00**

AMERICAN MEDICAL ASSOCIATION

William Walton Massey

Dr. William W. Massey of Quincy died at his home on Oct. 4, 1950. For several years he had suffered from a heart ailment, but remained in active practice until death came suddenly from acute coronary thrombosis as he slept. He was 62 years of age.

Born at Barwick, Ga., in 1888, Dr. Massey was educated in his native state, receiving his medical degree from the University of Georgia in 1911. He entered the private practice of medicine in Morven, Ga., and moved the following year to Moultrie, Ga., where he practiced for ten years.

In 1923, Dr. Massey located in Quincy, where he was active throughout the remainder of his life in all civic, professional and church affairs. He was an active member of the visiting staff of the Gadsden County Hospital. A Mason and a member of the American Legion, he was also a leader in the First Baptist Church and had served as chairman of the board of deacons. In World War I he served with the medical corps and in World War II on the local selective service board.

Dr. Massey was a past president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, a member of the Florida Medical Association and a fellow of the American Medical Association.

Surviving are his widow, the former Margaret Ward of Atlanta, Ga.; four sons, Dr. J. Lloyd Massey and Dr. George H. Massey, both in practice in Quincy, and W. W. Massey, Jr., and James W. Massey, also of Quincy; six grandchildren; and four brothers and two sisters.

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What Every Doctor Should Know

This is a period when men in every field are taking inventory. Conservationists are pointing with alarm to depletion of forests, extinction of certain species of birds and animals, erosion of soil and are urging us to work together to conserve the natural resources of America which heedless short sighted people have abused to further their own ends. They urge us to work together because destructive influences cannot be combatted except by active participation in a constructive way.

This wanton waste is in evidence everywhere. The American way of life has been shifting under our feet and advantages we took for granted in the world of free enterprise have been sifting downhill into a new swift stream — a stream of political invective carrying destructive elements aimed at medical shores.

In one instance, a recent column by George Dixon in the Chicago Herald-American, October 12, 1950, reveals a new trick employed against the medical profession by one India Edwards, a lady who is chairman of the woman's division of the Democratic National Committee. She has started a new type pyramid club. Her system according to Mr. Dixon is as follows: "Telephone 10 of your friends," she urged, "and ask each of them to call 10 others to join in an attack upon the A.M.A. for its opposition to the socialized medicine program.

"Mrs. Edwards, who used to be a society editor before she acquired the common touch, declared that each caller of ten friends should denounce the

nation's doctors for the advertising campaign they are putting on this month. She explained that this would be the most efficacious way of counteracting the A.M.A. campaign."

While Mrs. Edwards is recruiting members for her new club to work against the doctors what are the doctors' wives doing? This, each doctor should ask his own.

If she fails to join the Auxiliary to her husband's medical society which in organization is able to combat such propaganda, she becomes a passive link in the chain which is being forged by politically energetic women to fetter the doctor's freedom.

If we want to keep our sound footing in the field of medicine we have to call in the ground crew and sand bag the areas where this insidious current is eating away the foundations.

When a farmer has to change the angle of his ploughing to hold his ground, the whole family pitches in. It's time the doctor's family rallied to his side and pitched in. There is work to do. So let's organize.

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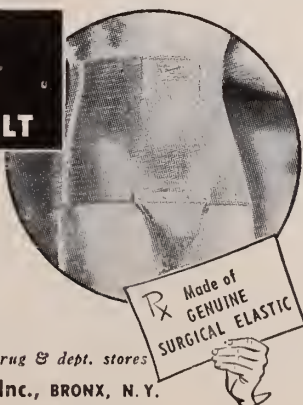
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GYNECOLOGY—Intensive Course, Two Weeks, starting February 19. Vaginal Approach to Pelvic Surgery, One Week, starting March 5.

OBSTETRICS—Intensive Course, Two Weeks, starting March 5.

MEDICINE—Intensive General Course, Two Weeks, starting April 23. Gastro-enterology, Two Weeks, starting May 14. Gastroscopy, Two Weeks, starting March 5. Electrocardiography & Heart Disease, Two Weeks, starting March 19.

PEDIATRICS—Intensive Course, Two Weeks, starting April 2. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 16. Cystoscopy, Ten Day Practical Course, every two weeks.

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*February 5, 6, 7, 1951**Municipal Auditorium Annex**Atlanta, Georgia*

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Lahey Clinic | 1. Diagnosis of Cancer of the Stomach.
2. Medical Management of Peptic Ulcer. |
| DR. FRED W. RANKIN
Lexington, Ky. | 1. Modern Management of Cancer of the Colon.
2. Modern Trends in the Management of Rectal Cancer. |
| DR. RICHARD B. CAPPS
Northwestern University | 1. Treatment of Cirrhosis of the Liver.
2. Diagnosis and Treatment of Amebiasis and Amebic Hepatitis. |
| DR. WALTMAN WALTERS
Mayo Clinic | 1. Cancer of the Stomach.
2. Surgery of the Biliary Tract. |
| DR. WARREN W. QUILLIAN
Coral Gables, Fla. | 1. Infections in the Urinary Tracts of Children.
2. Diarrhea. |
| DR. GEORGE VAN S. SMITH
Harvard | 1. Dysfunctional Endometrial Bleeding.
2. Office Gynecology. |
| DR. JOHN PARKS
George Washington University | 1. Urinary Tract Infections in Pregnancy.
2. Placental Complications. |
| DR. J. S. SPEED
University of Tennessee | 1. Minor Surgery of the Foot.
2. Chronic Rheumatic Arthritis. |
| DR. IRVINE H. PAGE
Cleveland Clinic | 1. Diagnosis of Hypertension.
2. Treatment of Hypertension. |
| DR. JOHN R. GODWIN
Ochsner Clinic | 1. Melanomas.
2. Iodine -131. |
| DR. GEORGE J. THOMAS
University of Pittsburg | 1. Fire and Explosive Hazards in Hospitals. |

The following speakers have not announced their topics but will talk on the general subjects given:

- DR. WALTER BAUER, Harvard, Arthritis.
 DR. WINCHELL MCK. CRAIG, Mayo Clinic, Neurosurgery.
 DR. CARLETON B. PEIRCE, McGill University, Radiology.
 DR. GRAYSON L. CARROLL, St. Louis, Antibiotics.
 DR. T. LEON HOWARD, Denver, Urology.
 DR. JOHN R. MOTE, Chicago, ACTH.
 DR. SAMUEL PROGER, Tufts Medical School, Cardiology.
 DR. F. WM. SUNDERMAN, Atlanta, Clinical Pathology.

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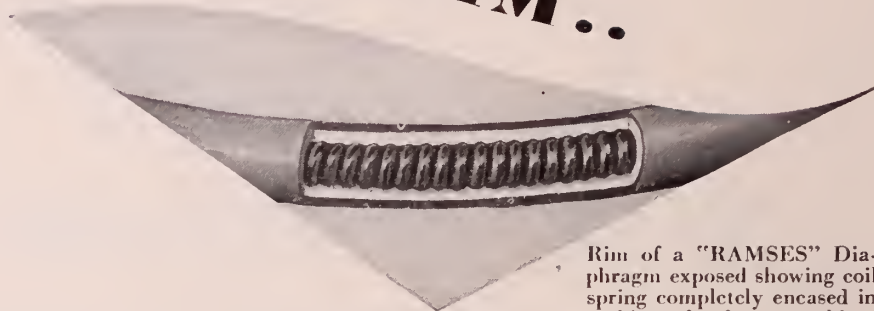
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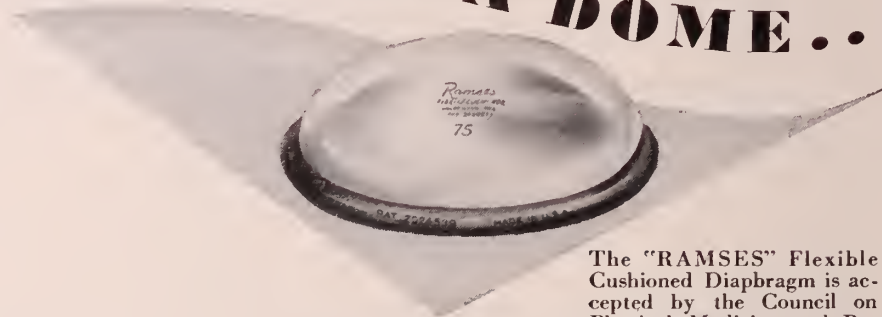
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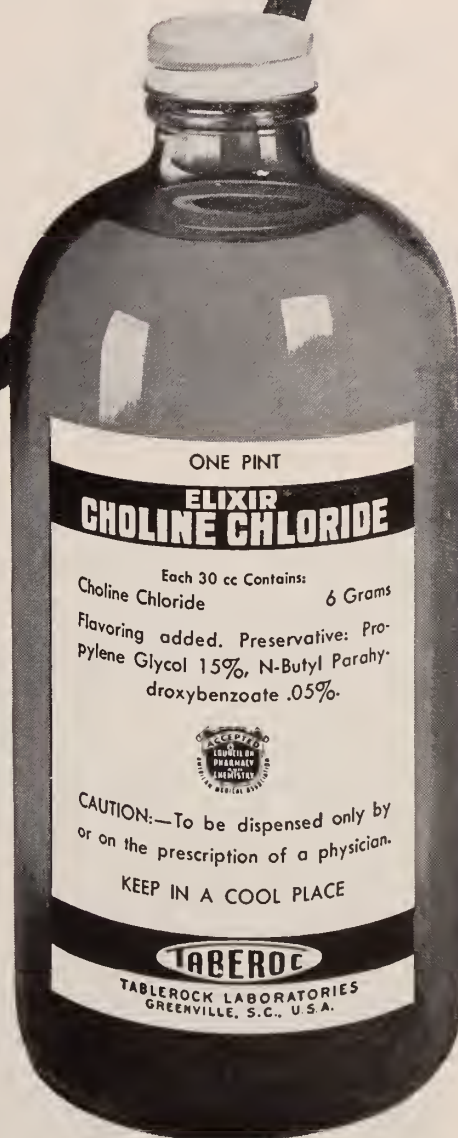
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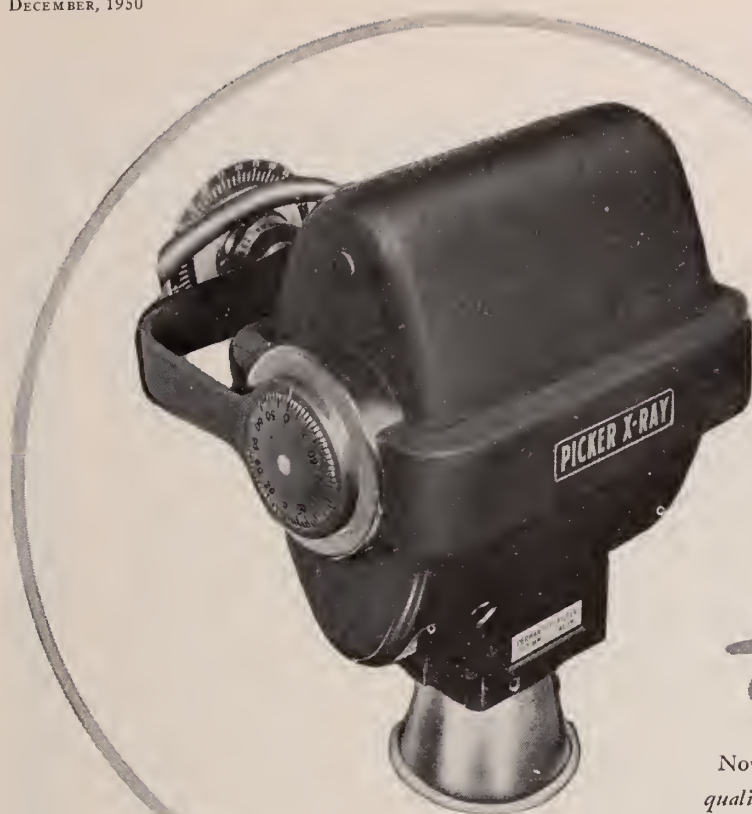
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Pensacola, 1951
B-Northeast	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	Orlando, 1951
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Bradenton-Sarasota, 1951
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	Vero Beach, 1951
Florida Specialty Societies			
Academy of General Practice	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	Hollywood, Apr. 22, '51
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	" "
Anesthesiologists, Soc. of	Ralph S. Sappenfield, Miami	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" "
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 2, '51
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, December, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 3, '50
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
Public Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Cleveland, Dec. 5-8, '50
Southern Medical Association	Hamilton W. McKay, Charlotte, N.C.	Mr. C. P. Loran, Birmingham	
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	St. Petersburg, April 4-6, '51
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg, Jan. 20-21, '51
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	E. L. McCafferty, Jr., Mobile, Ala.	

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				Total	Paid	
Bay	Daniel M. Adams, Jr., M.D. Panama City Hospital Panama City	Jack Corbitt, M.D. Box 961 Panama City		17	16	A-1-52 Arthur J. Butt, Jr., M.D. Pensacola
Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	72	
Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
Jackson *Calhoun	James T. Cook, Jr., M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	19	18	
Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	16	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	18	17	
Leon Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	48	100%	
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Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	3	
Taylor *Dirie-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	217
Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 825 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	42	100%	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	248	240	
Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	27	100%	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
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St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	13	100%	B-4-51 Cleveland D. Cochrane, M.D. Daytona Beach
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Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	142	139	
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Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 1102 W. Cass St. Tampa	1st Tuesday 8:00 P.M.	155	152	C-5-51 M. Crego Smith, M.D. Clearwater
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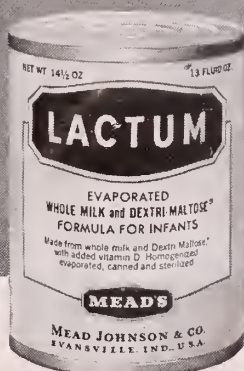
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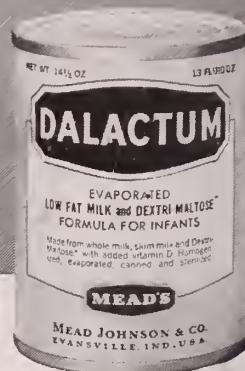
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Vol. XXXVII

JANUARY, 1951

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Subdiaphragmatic Abscess

Frederick H. Bowen
Arthur L. Hardie, Jr.



Viral Hepatitis

Henry Fuller



Plastic Surgery

George W. Robertson



Vivisection

An Editorial



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1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.
2. Beckman, H.: Treatment in General Practice Philadelphia, Saunders, 6th ed., 1948, 744.

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Most, H., and Van Assendelft, F.:
Ann. New York Acad. Sc. 53:427 (Sept. 15) 1950.



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Dowling, H. F.; Lepper, M. H., Caldwell, E. R., and Spies, H. W.:
Ann. New York Acad. Sc. 63:433 (Sept. 15) 1950.

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Harding, F. E.: *West. J. Surg. Obst. & Gynec.* 52:31 (Jan.) 1944

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Neustaedter, T.: *Am. J. Obst. & Gynec.* 46:530 (Oct.) 1943.

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Glass, S. J., and Rosenblum, G.: *J. Clin. Endocrinol.* 3:95 (Feb.) 1943

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Perloff, W. H.: *Am. J. Obst. & Gynec.* 58:684 (Oct.) 1949.



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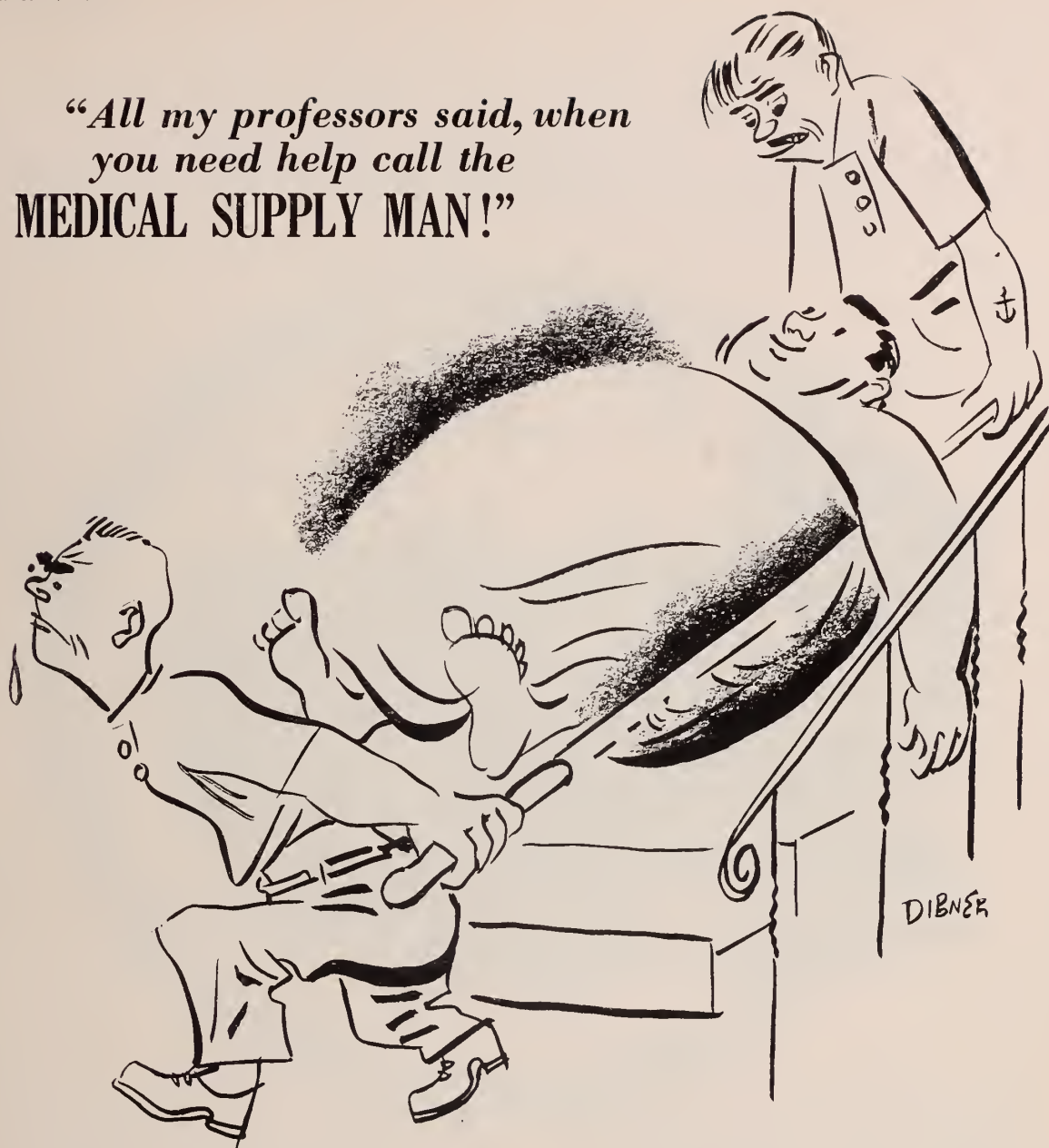
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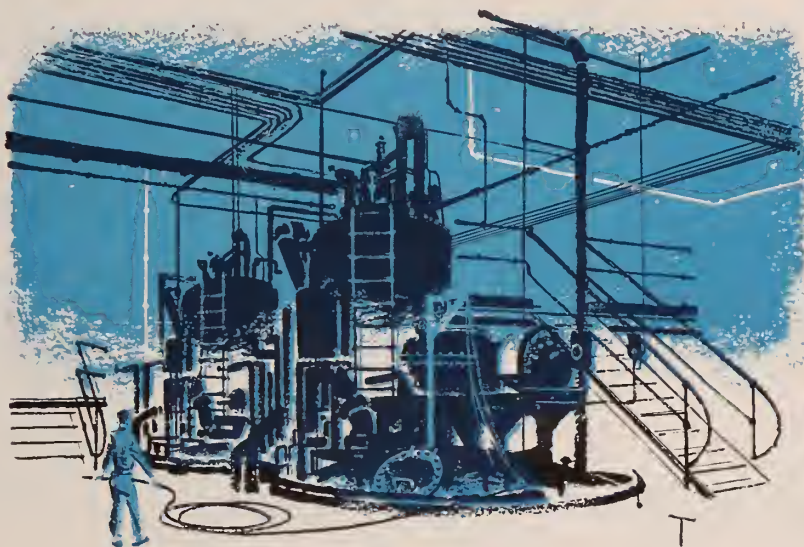
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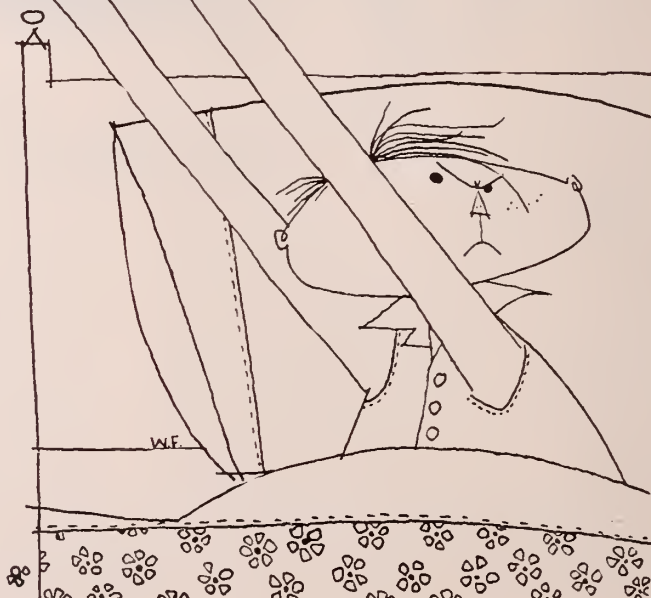
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*Diefenbach, W. C.,
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(1) Schweigert B. S.: Significance of Vitamin B₁₂ and Related Factors, *J. Am. Dietetic Assoc.* 26:782 (Oct.) 1950.

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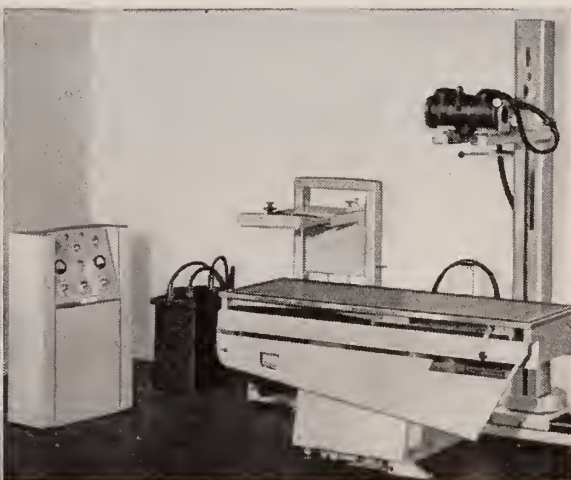
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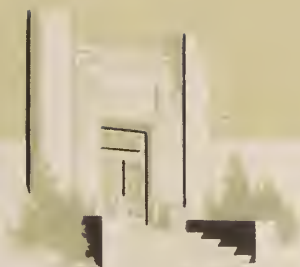
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Subdiaphragmatic Abscess with Special Reference to Its Roentgen Ray Visualization

FREDERICK H. BOWEN, M.D.

AND

ARTHUR L. HARDIE, JR., M.D.

JACKSONVILLE

A subdiaphragmatic abscess is not an unusual surgical complication. The roentgenologic visualization of the extent and location of a subdiaphragmatic abscess, however, after the injection of air and/or radiopaque substances is a comparatively recent refinement in the treatment of this condition. The accurate localization and visualization of this abscess contribute materially to intelligent treatment in that they permit the incisions for drainage to be accurately placed in the more dependent portions.

We are presenting 3 cases in which subdiaphragmatic abscesses were visualized roentgenologically after the injection of air or lipiodol or both. Visualizing the extent and exact location of these abscesses enables one to place the surgical incision in a more dependent position for drainage of the abscess than does dependence on various classical types of incisions which have been described. In case 2, for example, there was no pus in the posterior part of the right subdiaphragmatic space, but the abscess was visualized by injection of lipiodol and air, and it was subsequently drained anteriorly. Posterior drainage of that particular abscess would not have been possible. Three cases of subdiaphragmatic abscess are presented.

Report of Cases

Case 1.—E. M. R., a 19 year old Negro woman, was admitted to the Duval Medical Center on Dec. 25, 1945, about two hours after having been in an automobile accident. She was complaining of severe pain over the entire abdomen, which was most severe in the right upper quadrant, and she also complained of pain in the superior part of the right shoulder. There was tenderness over the entire abdomen with rebound tenderness which was more pronounced in the right upper quadrant; there was moderate rigidity in the right upper quadrant. The abdominal roentgenogram gave negative evidence. Two hours after admission the blood pressure was 95 systolic

and 60 diastolic, and after 1,000 cc. of 10 per cent glucose in normal saline was given, the blood pressure returned to 110 systolic and 70 diastolic and was maintained at that level. The initial white blood cell count was 22,800 with 86 per cent polymorphonuclear neutrophils, and the red blood cell count was 3,390,000. The urine showed no gross blood. It was our impression that the patient had a severe contusion of the liver with irritation of the diaphragm on the right side, causing referred pain to the right shoulder.

The following day there was little change in the patient's condition, but the temperature was 100.2 F. The urine showed gross blood. Four days after admission the temperature was 103 F., and the administration of 20,000 units of penicillin every three hours was begun.

Seven days after admission the temperature was still elevated, and a mass was palpable in the right upper quadrant 3 cm. below the costal margin, which was tender and flat to percussion, and this was considered to be the liver. Roentgenograms were taken, and the report was as follows: "There is increased density throughout the right lower lung field corresponding to the right lower lobe accompanied by approximately 4 cm. elevation of the right diaphragm, and there is a well defined collection of gas in the right subphrenic region. The cardiac shadow is deviated slightly to the left.

"There are numerous small areas of decreased density in the right upper quadrant in the abdominal plate made in the supine position, which is probably due to free abdominal gases. Retrograde studies of the right kidney reveal considerable distortion of the entire inferior calyx accompanied by extravasation of the media into the central portion of the right lower renal sulcus. The upper renal area does not reveal abnormal changes. The left kidney is essentially negative (fig. 1).

"Impression: (1) Traumatic atelectasis, right lower lobe, with probable accompanying hemothorax, (2) ruptured viscus, abdominal, and (3) ruptured kidney."

The patient was then given sulfadiazine in addition to penicillin. The white blood cell count was 25,500, with 82 per cent polymorphonuclear neutrophils, and the hemoglobin was 38 per cent. The red blood cell count was 1,940,000. Examination of the urine showed one to two red blood cells per high power field. On Jan. 2, 1946, the patient received 500 cc. of whole blood.

On January 6, roentgenograms were made, and the report was as follows: "The increased density previously observed in the right lower lung field has diminished considerably in amount. Elevation of the diaphragm is again observed, but remains at the same level (eighth costochondral junction). Subphrenic collection of air has increased in amount, and there is a definite shifting of fluid level observed in the upright and left lateral decubitus

views (figs. 2 and 3). The lowermost extent of this air space is at the level of the interspace between the tenth and eleventh ribs in the midaxillary line; however, the lowermost level of frank cavity type area is underlying the ninth rib, midaxillary line. The inferior portion of the air-filled area (fluid level) is situated in the eighth interspace posteriorly in the midline.

"There is a definite fluid level observed in all upright films of the abdomen on a level with the inferior margin of the body of the second lumbar vertebra, and extends from the lateral abdominal wall to the midline. Lateral projection reveals this fluid line to extend forward to approximately the midline of the abdomen with extension to the posterior abdominal wall (fig. 4).

"Impression: (1) Subphrenic abscess, right, and (2) free fluid, abdominal, right."

There was pronounced tenderness at the right costo-vertebral angle and in the right upper quadrant of the abdomen. There was dullness at the base of the right lung. On January 8, an attempt to drain the posterior subdiaphragmatic abscess on the right side was made. A longitudinal incision was made in the posterior axillary line to the perirenal space, where blood, pus and urine were found. Attempts to needle upward for subdiaphragmatic abscess were unsuccessful. Two cigarette drains and two No. 21 urethral catheters were sutured into the wound.

On January 10, another operation was performed. An incision was made in the posterior axillary line over the tenth and twelfth ribs; a portion of the twelfth rib was resected, and an abscess cavity entered. Much pus was evacuated. Two cigarette drains and two urethral catheters were left in the abscess cavity. The catheters were irrigated daily with Dakin's solution.

The patient was given a total of 6,500 cc. of blood in transfusions and large doses of vitamins. Her condition gradually improved. On the seventh postoperative day her temperature was 99 F. and remained there approximately one week before returning to normal. She was discharged on March 2, 1946.

Repeated cultures of the pus showed *Aerobacter aerogenes*, *Escherichia coli*, and *Pseudomonas aeruginosa*.

Case 2. — O. A., a 38 year old Negro man, was admitted to the Duval Medical Center June 21, 1947, complaining of a strangulated left inguinal hernia. He stated "it had been down" and not reducible for a week, but he had been having obstructive symptoms for only three days. At operation the strangulated bowel was not entirely gan-



Fig. 1. — There is distortion of the entire inferior calyx of the right kidney accompanied by extravasation of the dye.



Fig. 2. — In this roentgenogram note the high diaphragm on the right with the collection of air and fluid beneath it. Also note the fluid level on a line with the inferior margin of the second lumbar vertebra.

grenous, but there was a perforation of about 1 cm. present with a scrotal abscess. The perforation was closed, and the hernia was repaired.

The postoperative course was particularly stormy, and after about two weeks distention was still present in spite of continuous suction, chemotherapy and other supportive measures. Diarrhea and edema of the ankles also developed. The serum protein on July 21 was 5.55 Gm., with an albumin globulin ratio of .89 to 1. Plasma was administered, and a high protein diet was ordered. We believed he had a pelvic abscess.

On August 15, there developed a thrombophlebitis of the left arm. At that time 2 plus pitting edema of the feet and ankles, a palpable liver and a hard mass in the rectum were present. The thrombophlebitis was treated with chemotherapy, a stellate block, and an ace bandage to the arm. He improved and was discharged on September 4. He was seen in the Surgical Clinic September 15 and was readmitted because of ascites, an enlarged liver and edema of the ankles. At the time of admission, examination showed a thin Negro man who appeared chronically ill. The temperature was 99 F., the pulse rate 110 and the blood pressure 116 systolic and 78 diastolic. There was no jaundice. There were swelling and tenderness in the right upper quadrant with shifting dullness. An herniorrhaphy scar was present in the left lower quadrant with a small draining area at the upper end of the incision. There was 2 plus pitting edema of the ankles. Impressions were: (1) multiple liver abscesses, (2) possible subphrenic abscess, and (3) possible cirrhosis of the liver.

The white blood cell count was 15,350 with 82 per cent polymorphonuclear neutrophils, and the hemoglobin was 49 per cent with a red blood cell count of 2,560,000. The icterus index was 5 units. The cephalin flocculation after twenty-four hours was 0, and after forty-eight hours 1 plus. The urine showed an occasional pus cell.

There was little change in the patient's condition until September 25, when the temperature was elevated to 102 F. and the pulse rate to 140. On September 26 the subdiaphragmatic space was aspirated posteriorly, and nothing was obtained. Anterior aspiration yielded approximately 300 cc. of greenish yellow pus which showed gram-negative rods and gram-positive cocci, but no amebas. After aspira-

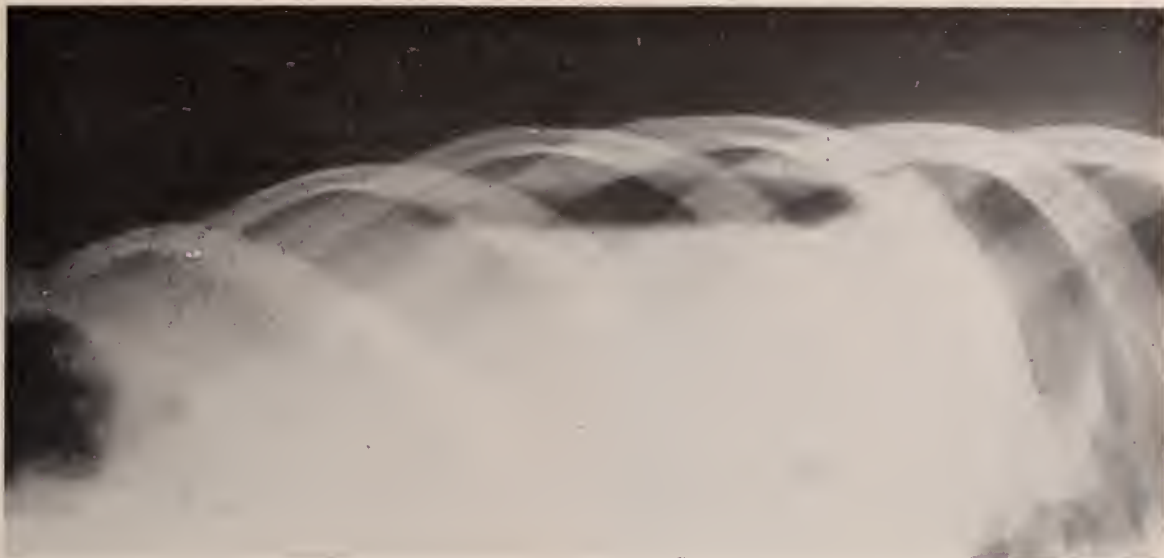


Fig 3.—Note the shift in the fluid-level in this lateral decubitus roentgenogram.

tion, 150 cc. of air and 20 cc. of lipiodol were injected into the cavity and roentgenograms were taken, with the following report: "Numerous films of the abdomen centering over the liver show a round area of decreased density which appears to be in the liver containing fluid level and opaque medium. Some of this opaque medium appears to be running downward into the abdomen. This may represent a liver abscess, but it may communicate with the peritoneal cavity (fig. 5)."

Immediately following aspiration the temperature rose to 104 F., but soon returned to 102 F. On September 29, the administration of 300 mg. of streptomycin every three hours was started. The following day another roentgenogram was made (fig. 6), the abscess was incised and drained anteriorly, and a catheter was left in the cavity for irrigation. The patient gradually improved, and the temperature descended to normal on October 3 and remained normal.

On October 18, lipiodol was injected into the cavity and roentgenograms were again taken with report as follows: "Injection of the sinus in the right upper quadrant shows the lipiodol to pass medially and it is located in a pocket about 4 cm. beneath the lateral chest wall. The cavity measures 10 by 3 cm. with its longest diameter up and down. The superior end of this cavity is 3 cm. below the diaphragm (figs. 7 and 8)." The capacity of the cavity measured approximately 20 cc. He was discharged on October 29.

The patient received 6,000 cc. of plasma and 1,000 cc. of whole blood while he was in the hospital, as well as large doses of vitamins, protein extract, crude liver extract and choline chloride.

Case 3. — L. C. E., a 55 year old man, was admitted to St. Luke's Hospital on Jan. 5, 1946, complaining of pain in the chest of one week's duration. There had developed a "cold" five days before he was admitted to the hospital, and this was characterized by excessive nasal discharge. He began to vomit about the time the "cold" appeared. He experienced what he called "smothering spells," and it seemed likely that he meant difficulty in taking a full breath by this statement. He had received one injection of penicillin a few days before coming to the hospital. On further questioning he stated that he had had pleurisy for some months. He reported that he had lost 20 pounds in the two to three months preceding his admission. He also complained of vague digestive disturbances. The history on this patient was not satisfactory as it was difficult to get him to focus his mind on his complaint. He tended to

drop off to sleep frequently, and he muttered at times.

On physical examination the patient was noted to be a well developed, poorly nourished man who was in no acute pain. Examination of the chest revealed moist fine rales and a friction rub over the posterior area on the right side. Examination of the heart revealed a soft systolic murmur at the apex. The temperature on admission was 102 F., the pulse rate was 100, and the respirations were 26. The examination of the blood showed a red blood cell count of 3,940,000 and a white blood cell count of 18,000



Fig. 4.—Lateral projection showing the upper and lower fluid levels.



Fig. 5.—Roentgenogram made immediately following aspiration of the abscess and injection of air and lipiodol.

with 76 per cent polymorphonuclear cells. The urinalysis revealed an albumin of 1 plus. Penicillin therapy was administered with little improvement in the general condition.

"Roentgen examination of the chest showed a decided elevation of the right leaf of the diaphragm with pleural thickening overlying it, and fluoroscopy revealed that there was no movement of the diaphragm with respiration (fig. 9). A roentgenogram of the abdomen showed the lower part of the liver a little lower than average. No other abnormal condition was noted. Impression is that of an infectious process beneath the right side of the diaphragm, either subdiaphragmatic abscess or possibly liver abscess." The roentgen studies on this patient were carried out by Dr. John A. Beals.*

The patient continued to receive penicillin and was given 1,000 cc. of 5 per cent glucose and saline intravenously two times a day. On January 10 at 10 p.m., while the patient was receiving an intravenous infusion, there developed dyspnea, stridor and cyanosis. An examination of the chest at that time showed many fine moist rales in the lower half of both sides posteriorly. The pulse rate was 98, and the blood pressure was 200 systolic and 80 diastolic. The patient was treated for acute left ventricular failure with an oxygen tent and 3 cat units of cedil-anid intravenously. He speedily recovered from this episode. The white blood cell count four days after admission was 20,250 with 97 per cent polymorphonuclear cells. The blood Kahn test gave negative results. Eight days after admission one of us (F. H. B.) was asked to see this patient in consultation. Examination revealed that the right lobe of the liver was palpable just below the costal margin and the abdomen was greatly distended. It was our impression that the patient had a subdiaphragmatic abscess or a liver abscess.

The following day, under local anesthesia, a needle was inserted in the eleventh interspace in the midscapular line posteriorly into the right posterior subdiaphragmatic space. Pus was encountered which was bloody and thin, had no odor and did not coagulate upon standing. Three hundred and fifty cubic centimeters of this pus was aspirated. After shifting the patient and injecting air, an additional 100 cc. of dark brown, thick, odorless pus was obtained. An immediate gram smear and an examination for amebas gave negative results. An immediate roentgenogram taken with the patient in the lateral position showed the air to be in the subdiaphragmatic space (fig. 10). The thick brownish fluid which was aspirated was believed to be grossly typical of amebic pus. The patient was subjectively improved by this aspiration, and his respirations were much easier. A

*Dr. Beals died Nov. 6, 1950.

roentgenogram taken two days later revealed that a large amount of fluid was still present in the subdiaphragmatic space. Signs and symptoms of arterial insufficiency of the right foot developed, and on January 15 the right lumbar sympathetic ganglions were blocked with 10 cc. of 1 per cent novocain to each of four ports.

On January 19 the abscess was again aspirated. A No. 22 needle was inserted through the right eleventh interspace, 2 inches from the spinous processes of the vertebrae. After pus was encountered, this needle was withdrawn and a large No. 15 needle was inserted into the subdiaphragmatic space. The needle was irrigated with .9 per cent sodium chloride solution, and air was injected to facilitate withdrawal of the pus. Nine hundred cubic centimeters of coffee-colored thick pus which jelled on standing was aspirated from the subdiaphragmatic space. Microscopic examination of the pus identified the cysts of *Endamoeba histolytica*, and there was an occasional motile form present. Three examinations of warm stools for amebas gave negative results. An electrocardiogram showed signs which were suggestive of mild cardiac infarction. The administration of emetine hydrochloride was begun, and the patient was given 1 grain daily subcutaneously for eight days.

The temperature rose to 103 F. following the aspiration on January 20, but slowly descended and remained normal after January 25. On January 29, 1,000 cc. of yellow pus was aspirated over a period of forty-five minutes from the right posterior subdiaphragmatic space. Air and .9 per cent sodium chloride solution were again injected to facilitate the aspiration of the thick pus. Roentgenograms, made of the abdomen on January 30, were reported as follows: "Films, in two different postures, to show fluid levels again demonstrated large accumulation of air or gas. Most of this is between the liver and the diaphragm, but I feel sure there is a connection with the general peritoneal cavity allowing some of the air to appear under the left side of the diaphragm again well below the liver. There are no signs of loculated cavities within the liver (figs. 11 and 12)." It was noted on January 29 that there had developed a dry gangrene of the third, fourth and fifth toes of the left foot. Lumbar sympathetic block was repeated on February 2 and 12. On February 19, a left supracondylar amputation was performed under refrigeration anesthesia, and the left common femoral vein was ligated under local anesthesia at that time. The patient stood this procedure well and was returned to the room in good condition. The subdiaphragmatic space was aspirated five times over a period of forty days. The patient



Fig. 6.—Roentgenogram made the day following the injection of lipiodol.

continued to improve. On April 6 a plaster pylon was made, and a few days later he was discharged.

The material aspirated from the subdiaphragmatic space was cultured on numerous occasions, and no organisms were found. On January 17 cephalin flocculation was plus 1 in twenty-four hours and plus 3 in forty-eight hours. Routine agglutinations were negative on January 16. Sputum examination for acid fast organisms and for amebas gave negative results on January 21. No amebas were found on subsequent aspirations of the abscess following the subcutaneous injections of emetine.

This patient returned to his normal work in a dry cleaning plant, using the plaster pylon which we had made for him. He stood on his remaining leg and worked some sort of a lever at the dry cleaning plant with the plaster pylon. Approximately one and one-half years after the discharge from this hospital there developed an intractable ulcer over the heel of his remaining leg. He was admitted to the Duval Medical Center at that time, and one of us (F. H. B.) performed a right lumbar sympathectomy. He still had severe pain in his heel; so the posterior tibial nerve was crushed with much relief of pain. This ulcer healed slowly over a period of six or seven months. After the ulcer healed, the patient had severe phantom pain in his amputated extremity, as well as pain in the remaining leg. Approximately two years after his discharge from St. Luke's Hospital a prefrontal lobotomy was done by Dr. James G. Lyerly to help in alleviating this pain. The patient has had moderate relief with this operation.

Comment

There is no general agreement that aspiration in attempts to localize a subdiaphragmatic abscess is an accepted or a safe procedure. Coller and Ransom stated: "Attempts at localization of an abscess by aspiration of a suspected area is a procedure which is quite generally condemned. Even though an abscess is present the searching needle may fail to enter the cavity thus giving the erroneous impression that no pus is present. Moreover, such procedures may result in the spread of septic material to uninvolved portions of the peritoneal cavity or pleura." Firor in Christopher's Surgery, however, expressed another opinion: "In any case of doubt [as to the presence of subdia-



Fig. 7. — Lipiodol injection of the abscess cavity nineteen days following drainage.



Fig. 9. — This roentgenogram shows a marked elevation of the right leaf of the diaphragm with overlying pleural thickening.



Fig. 8. — Lateral view of abscess cavity showing its anterior location.



Fig. 10.—Roentgenogram showing the fluid level in the right subdiaphragmatic space. The aspirating needle through which the air was injected was still in place when this roentgenogram was taken.

phragmatic abscess], aspiration of pus should be attempted." In our hands the aspiration of the subdiaphragmatic space has proved a safe procedure. It has also been an accurate procedure. When pus has been present we have been able to find it with the aspirating needle. In addition to the cases reported, we have carried out this procedure in 1 other case and, during this period of time, we have in 4 cases performed aspiration with negative results. No pus was ever demonstrated subsequently in these 4 cases.

It has been said that the pleura or peritoneal cavities may be wounded in these aspirations. It is true that the pleura may be wounded unless its exact location is carefully remembered. In Callander's Surgical Anatomy the exact level of the costodiaphragmatic junction is noted: "The costodiaphragmatic level begins at the inferior level of the anterior costomediastinal line of reflection located at the level of the xiphoid and passes laterally and inferiorly behind the seventh costal cartilage and the seventh intercostal space. In the mid-clavicular line it crosses the eighth costochondral junction and continues its lateral descent crossing under the tenth rib in the midaxillary line. Posteriorly, the line of reflection ascends slightly as it approaches the vertebral column. It crosses the eleventh rib and part of the twelfth rib at the lateral margin of the sacrospinalis muscle. It reaches the column at the level of the twelfth thoracic spine about 1 centimeter inferior to the head of the eleventh rib." Occasional anomalies of the ribs may be noted. Sobotta and McMurrich stated:

"The twelfth rib is often very short and varies greatly in length." Deaver in his book on Surgical Anatomy stated: "The number of ribs may not only be increased but the twelfth rib may be excessively short and the first may be incomplete." Additional information concerning the anatomy of the ribs may be found in Gerrish's Anatomy and in Morris' Anatomy, tenth edition.

We do not believe that anyone with an accurate knowledge of the peritoneum who is trying not to wound the peritoneum will injure it in doing one of these aspirations. As stated, however, the danger to the pleura is real, but one will rarely if ever wound the pleura if one remembers carefully the anatomy of the lowermost extent of the pleura. In most instances of subdiaphragmatic abscess the diaphragm rises high, the costophrenic pleural angles are obliterated, and aspiration is usually safe from pleural contamination.

Summary

Three cases of subdiaphragmatic abscess are presented. It is evident in cases 1 and 2 that the roentgenographic visualization of the exact location and extent of the abscesses was extremely helpful in placing the incision so as accurately to drain them. In case 3 the injection of air into the abscess helped us ascertain its exact location. The fact that there were no pyogenic organisms in this third subdiaphragmatic abscess and that it contained only amebas enabled us to treat it by aspiration and the intramuscular injection of emetine without resorting to external surgical drainage.

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Discussion

DR. ARTHUR L. HARDIE, JR., Jacksonville: In this discussion I shall stress some of the points which we regard



Fig. 11.—Anteroposterior roentgenogram made in the erect position showing the fluid level in the right subdiaphragmatic space.

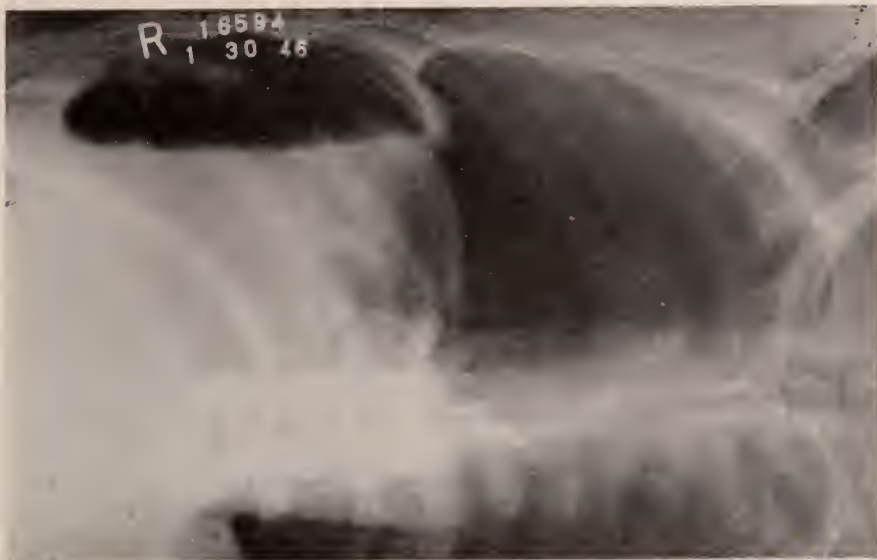


Fig. 12.— Right lateral decubitus roentgenogram showing the fluid level in the right subdiaphragmatic space.

as of particular importance on this subject of subphrenic abscess.

As borne out in the paper just given, the anatomy of the region is important from a standpoint of diagnosis and therefore in the institution of proper treatment.

Philip Thorek in May, 1947 Surgery clearly described the anatomy and relations of the so-called six subphrenic spaces. Martinent, as far back as 1898, accurately described these spaces, and in 1908 Barnard amplified the description and included the surgical aspects.

The subphrenic space is looked upon as that space between the diaphragm above and the transverse colon and mesocolon below. This area is divided by the liver into three suprahepatic and three infrahepatic portions. The space to the left of the falciform ligament is known as the left suprahepatic space. The right suprahepatic space is divided into a large anterior and a small posterior space by the right lateral ligament which is a prolongation of the coronary ligament. The coronary ligament is made up of the peritoneal reflection in the center of which is the bare area or extraperitoneal area of the liver. The right infrahepatic space is that space below the liver and to the right of the descending portion of the duodenum. The left infrahepatic space is divided into anterior and posterior spaces by the stomach, the posterior being the lesser peritoneal cavity.

In 1933 Ochsner and Graves reviewed and reported on a world series of 3,372 collected and personal cases of subdiaphragmatic abscess. We have no idea of the number of cases reported since then, but undoubtedly the occurrence has been markedly reduced since the advent of chemotherapy and antibiotic therapy. They reported at that time that in their experience only 30 per cent of subphrenic infections actually proceed to suppuration and abscess formation. Certainly today with our chemotherapy and new antibiotics this percentage has been drastically reduced. Any patient with abdominal contamination or suppurative process is now immediately given large doses of the drugs prophylactically. In 88 per cent of the cases of subphrenic abscess reported there was a suppurative process within the abdominal cavity. In approximately 60 per cent of all cases it originated from the appendix, duodenum, or stomach; in 12 per cent from the liver and biliary passages; and in 20 per cent from the kidneys. In 3.4 per cent it was blood borne, and in approximately 3 per cent it arose from extensions from the thorax.

The clinical picture of subphrenic abscess, in general, is one of continued infection. During the postoperative

period, after common sources of infection such as residual abscess in the field of operation, in the wound, in the urinary tract, and in the respiratory system have been ruled out, one certainly must focus his attention on the subphrenic space.

Physical signs are often minimal and confusing. Frequently it is possible to localize infection to this general area, but the accurate differential diagnosis between basal pleural infections, subphrenic infections, liver abscess, and perirenal infections may at times be extremely difficult. With a subphrenic abscess, there frequently is a variable degree of pulmonary atelectasis and pleural reaction and effusion further to obscure the picture.

As shown by the cases reported, roentgen studies are certainly a valuable help in diagnosis and localization of the abscess. Roentgenograms should be taken with the patient in several different positions. Certain bacteria may cause gas formation in the abscess with resulting fluid level which can readily be detected on roentgenograms. If these conditions do not prevail, we, as indicated in the cases reported, advocate aspiration with injection of lipiodol or air and then roentgen examination. As brought out by Adams in the June, 1948 issue of *Surgical Clinics of North America*, in most instances the diaphragm rises high, the costophrenic pleural angles are obliterated, and aspiration is usually safe from pleural contamination.

DR. BOWEN, concluding: I appreciate the remarks made by Dr. Hardie. The patient with the amebic abscess of the liver and the subdiaphragmatic abscess was in critical condition. We thought because of the amount of liver damage present that none of the amebicides should be used other than emetine. On looking this subject up in the literature I found that all of the amebicides which were used at that time (in 1946) were toxic for the liver with the exception of emetine. Emetine, of course, is a general protoplasmic poison, but its main toxicity is for striated muscle, that is, for skeletal and cardiac muscle. We did not use any drug except emetine because of these reasons. As brought out in the body of the article, I believe that these aspirations are relatively safe if one uses a certain amount of care. In a series of diagnostic failures in subdiaphragmatic abscess reported by Dr. Lehman, the diagnosis of subdiaphragmatic abscess is accurate in about 50 per cent of the cases. Unnecessary operations upon these ill patients should not be done in 50 per cent of the cases. Adequate aspiration will help to avoid unnecessary operations. Again, I want to thank Dr. Hardie for the discussion.

Viral Hepatitis: Present Concept and Some of Its Problems

HENRY FULLER, M.D.
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The present concept of viral hepatitis is but a few years old. For example, only twenty years ago one of the leading gastroenterologists in this country summed up the then prevailing opinions of catarrhal jaundice thus: "It is usually the result of inflammatory swelling of the mucous membrane of the terminal portion of the common bile duct. Catarrhal jaundice is never fatal. Recovery is complete and there are no sequelae."¹ Virchow first put forward the idea that the essential lesion in catarrhal jaundice was an obstruction in the common bile duct by a mucous plug.

At present, owing chiefly to biopsies of the liver, it is believed that the primary lesion in viral hepatitis is a diffuse inflammation of the liver and that there is no pathologic change in the common bile duct. The disease is sometimes fatal. It is true of course that viral hepatitis is usually a mild disease, and while there are no common sequelae, there are occasionally serious complications, and these may be fatal.

As far back as 1920, Stokes² suggested that the jaundice occurring in clinics for the treatment of syphilis might be an infectious disease instead of arsenical poisoning as had been supposed for many years. This idea was not popular at that time, and it took the great epidemic of jaundice following yellow fever vaccine in the last war to confirm Stokes' impression. Historically, it is interesting to know that epidemics of jaundice had been reported as a complication of smallpox vaccination as long ago as 1885.³ More recently, many sporadic cases have occurred in diabetic clinics.⁴ It is believed that these have been due to contaminated and improperly cleansed and improperly sterilized syringes used in the drawing of blood. Other cases have been attributed to convalescent serum.^{5a} One case has been reported in a blood bank worker accidentally pricked with a

needle.⁶ It has been suspected, but not proved, that in some cases the disease might even have been transmitted by biting insects.^{5a}

Proof exists that the virus of infectious hepatitis may be transmitted by feeding volunteers duodenal contents from patients with the disease⁷ and by inoculating volunteers with blood from patients with infectious hepatitis.^{5a} As to the transmission of serum hepatitis, it has been shown that this disease may be transmitted only by blood or its products.^{8a} So far, there is no proof that serum hepatitis is transmitted in any other way.

What is the relationship of infectious hepatitis to serum hepatitis? It is usual in discussing this to mention these differences and similarities:

	Infectious Hepatitis	Serum Hepatitis
Incubation Period	2-6 wks.	2-5 mos.
Mode of Transmission	Food-Water-Blood	Always Blood
Pathology	The two diseases are indistinguishable pathologically	
Onset	Abrupt	Insidious
Fever with Onset	Present	Absent
Constitutional Symptoms with Onset	Pronounced	Minimal

There are other differences also which are more difficult to prove, namely, differences in immunology. The important point to make now, however, is that for practical purposes, given a patient with viral hepatitis, how can one decide whether the case is one of infectious hepatitis or serum hepatitis? In the absence of a history of having received some blood fraction or blood itself, one calls the disease infectious hepatitis. If there is a history of recent transfusion or other blood fraction injection, one calls the disease serum hepatitis. There must be many cases in which the distinction is difficult. The etiologic agent of the two diseases has been proved to be a virus,^{5b, 8b} but there is no laboratory test, not even biopsy of the liver

From the Watson Clinic and Morrell Memorial Hospital, Lakeland.
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itself, that will differentiate between the two diseases.

With this introduction, I should like to present 3 cases:

Report of Cases

Case 1.—A 61 year old married woman was admitted to the hospital complaining of jaundice, nausea and anorexia of one week's duration. She had had no fever or pain. For some three months before admission, she had been getting a course of vaccine injections for Parkinsonism, which she had had for several years. The vaccine was old tuberculin, which had been prescribed by a neurologist. It was administered by a practical nurse. About twenty-four injections had been given. The nurse was a neighbor of the patient, and she gave injections to a number of other patients during this same period. There is no way of ascertaining what care was taken in cleansing and sterilizing syringes.

The patient had always been well except for mild Parkinsonism. She denied having ever used alcohol, and her diet seemed not to have been deficient.

Examination showed a moderately jaundiced, well developed woman with a liver palpable 4 cm. beneath the costal margin. The spleen was not palpable. The urine showed both bilirubin and urobilinogen. The icterus index was 33 units. The cephalin flocculation was 3 plus. A scout film of the abdomen gave no evidence of stones. A complete roentgen examination of the gastrointestinal tract, including barium enema, gave negative results.

The serum bilirubin remained elevated for a year. It is now normal. At present, the liver and spleen are not palpable. Hemorrhoids, which bleed occasionally, have developed. The patient has become anemic and had to be transfused. The serum proteins have always been normal. The urine always shows urobilinogen. The stools have never been acholic. Ascites has never been present. The bromsulfalein test always has shown impaired excretion and now, one and a half years after the onset of the illness, shows 45 per cent retention in 45 minutes with a 5 mg. dose per kilogram of body weight.

Biopsy of the liver has not been done, but with the long duration of one and a half years, the absence of pain at all times, and the obvious lack of complete obstruction, it seems certain that this patient has cirrhosis, and it is likely that it developed from viral hepatitis.

Case 2.—A woman, aged 53, a bookkeeper, complained of jaundice of nine months' duration when first seen in September 1947. The onset of her illness had been insidious with epigastric distress and malaise, but without fever. Within a few days of the onset of these symptoms, jaundice had been noted. This has persisted for over two years. For three years prior to the beginning of the illness, the patient had taken many subcutaneous injections of estrogenic hormones and vitamins for the relief of symptoms probably associated with the menopause. These injections were taken in numerous doctors' offices, some elsewhere. Her diet had always been excellent, and she had always been abstemious as to alcohol.

Physical examination showed a well developed, well nourished, moderately icteric woman with a large smooth liver and a barely palpable spleen. The urine showed bilirubin and urobilinogen. Blood counts were normal. The icterus index was 29 units. The cephalin flocculation was normal. A complete roentgen examination of the gastrointestinal tract, including barium enema, gave negative results. A cholecystogram, done despite the jaundice, showed a normally filling and emptying gallbladder without evidence of stones. For two years, the patient has been on a high carbohydrate, high protein, low fat diet, has taken methionine and choline frequently as well as

liver extract and vitamins, and has done badly. The liver continues to be palpable, the spleen has enlarged, she has become moderately anemic, hemorrhoids have developed, and, just lately, ascites has been present. The jaundice is now deeper.

Here, then, is a second case of cirrhosis developing as a complication, it is suspected, of viral hepatitis in a woman whose illness may have been induced by faulty technic from one or more of many hypodermic injections.

Case 3.—A 60 year old housewife was admitted to the hospital on Oct. 19, 1948 with jaundice of six months' duration. Her illness had begun with anorexia, nausea and slight fever without chills. The fever was of only about two weeks' duration. Jaundice was not noticed for four weeks after the nausea and anorexia began. She was hospitalized because of nausea, a loss of some 15 pounds in weight, and icterus. This patient also had had a series of vaccinations, hers being for arthritis. Nine months prior to the onset of the nausea, she had seen her doctor for stiffness of the fingers of both hands, and this vaccine therapy had been started. Exactly what the vaccine was is unknown, but two or three times a week, the patient received it at the doctor's office, his nurse administering it. She had never used alcohol in any form.

Physical examination showed a rather obese woman, markedly jaundiced. The liver and spleen were not palpable. The fingers, incidentally, did not show evidence of arthritis. The urine showed bilirubin and urobilinogen. The cephalin flocculation was 24 units and the icterus index was 57 units. The total protein, at first normal, fell after four weeks to 4.8 Gm., and a moderately severe hypochromic anemia developed. The prothrombin clotting time was moderately prolonged at first (forty-seven seconds). The serum cholesterol was 130 mg., the serum alkaline phosphatase 5.5 Bodansky units, and the blood urea nitrogen 30 mg. A roentgenogram of the gallbladder region did not show stones. A complete roentgen examination of the gastrointestinal tract, including barium enema, gave negative results.

Treated in the usual manner with bed rest and adequate diet, and transfused twice, the patient has apparently recovered. At least now, one and a half years later, the liver and spleen are not palpable, there is no anemia, there is no retention of bromsulfalein, she is not jaundiced, and she has no complaints. For about four months, however, improvement was slow. At the end of that time, there was slight jaundice and slight retention of bromsulfalein.

Discussion

These 3 patients all probably had viral hepatitis, and 2 of them now have cirrhosis. This has been confirmed in 1 by biopsy of the liver. A series of biopsies of the liver in all 3 would have been revealing. They were all women past the menopause and may fall into the category of the epidemic reported a few years ago in Copenhagen.⁹ In that epidemic, in which the disease was called infectious hepatitis, it seemed that women past the menopause were particularly vulnerable to this illness and that in them it was extraordinarily virulent.

Neefe^{5a} has shown that as little as 0.01 milliliter of plasma may transmit the virus of hepatitis. The virus is known to survive for long periods under widely varying conditions and resists many

procedures which eliminate or inactivate many infectious agents. There is a strong likelihood that perfectly well persons, many perhaps who have never been jaundiced, harbor this virus for years.^{5a} Neefe^{5a} concluded that "proper and thorough cleansing of syringes, needles and other instruments is of primary importance. If this is well done, it is *probable* that complete emersion in boiling water for five minutes would represent 'adequate' sterilization." Obviously, the presence of blood clots and other foreign materials tends to interfere with exposure of the hepatitis virus to disinfecting agents.

These cases illustrate another important and unsolved problem about viral hepatitis: Does portal cirrhosis develop as a complication of this disease? It is agreed that some sort of cirrhosis is sometimes a sequel of hepatitis, and cases 1 and 2 would confirm this, I believe, if it is accepted that viral hepatitis was present to begin with. Watson and Hoffbauer¹⁰ described a cholangiolitic type of cirrhosis, giving a terminal picture closely resembling Laennec's cirrhosis, which developed in patients who had had infectious hepatitis. Sherlock,¹¹ from biopsies of the liver of patients with hepatic disease following infectious hepatitis, found similar pathologic change. Kunkel and Labby¹² described a nodular type of cirrhosis as a sequel of infectious hepatitis different both grossly and microscopically from the diffuse regular pattern of bands of fibrous tissue intertwined among small areas of liver cells usually seen in Laennec's cirrhosis. This resembles the lesion described by Mallory¹³ in 1911, called by him "toxic cirrhosis or healed acute yellow atrophy." It is likely that the next few years will see this important problem settled.

Summary

I have tried, in a few words, to point out some of the present concepts of viral hepatitis. Three cases have been presented that may represent this disease contracted from improperly sterilized syringes. Lastly, the problem of cirrhosis developing from viral hepatitis has been mentioned.

Discussion

DR. FULLER, concluding: One of the 3 patients mentioned died, and autopsy revealed cirrhosis, grossly, somewhat typical of portal cirrhosis. The sections have not been examined yet. The spleen was large, and there was no thrombosis of the splenic vein. The question was raised as to whether or not this patient had Banti's syndrome, but, of course, I doubt if anyone could answer that question. It would have been a brave person who would have recommended splenectomy at any time during the course of her illness. It is likely that the next few years will bring an answer to the question, the important question, as to what sort of cirrhosis, if any, actually does develop from infectious hepatitis.

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Principles of Plastic Surgery

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There has been a widespread belief that the results in plastic surgery depend entirely upon the imagination and artistic ability of the individual surgeon. Actually this is true only to a limited extent, but the conception is most flattering and a great many plastic surgeons have tended to continue perpetration of this little hoax, or at least have made no serious efforts to explain the rather large group of definite principles upon which modern plastic surgery is based.

As in any other type of surgery, the primary aims are the elimination of disease and the restoration of function. The cosmetic appearance should be considered only after the complete accomplishment of the first two aims. Dr. Staige Davis, one of the fathers of American plastic surgery, once said that "the field of plastic surgery extends from the top of the head to the sole of the foot." Since there is little doubt of the veracity of this statement, it must follow that all good surgical principles are applicable to plastic surgery. In addition, the plastic surgeon must be guided by many special principles not applicable in general surgery. In this paper a few of the latter will be demonstrated.

Case 1 is that of a 31 year old white man, who was struck on the left side of the face in a barroom brawl. He suffered a depressed fracture of the left zygomatic arch which, because of the edema about the face and left eye, went unrecognized for several weeks. Although he came to operation one month after his accident, no callus was apparent in the fracture lines; so the Gilies procedure was elected for elevation. This procedure has been called the best application of practical anatomy in surgery. A horizontal incision is made in the hair-bearing area of the sideburn just anterior to the superficial temporal artery. This incision is carried down to and through the fascia over the temporalis muscle. An elevator is inserted under the fascia, and since this fascia invests the inner surface of the zygoma, it is a simple matter to slip

under the depressed portion and elevate to proper contour.

Case 2 illustrates the handling of scar lines which cross flexion creases. In hand infections in which the surgeon chooses the incision for drainage, flexion creases may be avoided, but often in reconstructive work the creases are necessarily involved. The patient in this case, a 24 year old Negro woman, suffered severe third degree burns of the palm of her right hand which exposed the flexor tendons of the fingers. A pedicle flap from the abdomen was immediately applied to prevent slough of the tendons. The suture lines were necessarily across the flexion creases and would have effectively immobilized the fingers. The construction of darts or tongue-shaped flaps eliminated these scar lines and resulted in a functional hand.

Case 3 illustrates the use of transposed flaps. The principle of transposition of flaps is widely used in reconstructive surgery. In this case, demonstrating one type, the patient was a 3 year old child with syndactylism between the fourth and fifth fingers of the left hand. Since fingers must have a web space in order to be freely mobile, flaps were constructed on each side of the hand and interpolated to form a good web. The denuded sides of the finger were covered with split skin grafts.

Case 4 shows another type of transposed flap, the Z-plasty. It is widely used to lengthen contracted scars. In this case the contracture was a long one, and so multiple Z-plasties were used.

Case 5 is that of a 21 year old Negro who suffered a long vertical laceration along the entire left side of his face from his forehead through both lids and the left side of his mouth. There were several plastic principles applicable here. The first is concerned with the fact that scars tend to contract along their long axis. When possible this type of scar is to be avoided especially around eyelids and other movable soft tissue. The laceration in this case was well sutured, but the contracture plus the keloidal tendency, which is so common in

the darker skinned races, caused an ectropion. This is often repaired by skin grafts, but that type of repair necessitates closing the eye for a matter of months; so the application of transposed flaps contributed to the principle of breaking up straight scar lines, with an excellent result for this patient.

Cases 6 and 7 illustrate several principles. The first principle is that adjacent tissue should be used for closure whenever possible, and the second is that primary closure of lesions should be made whenever possible. The third principle cannot be shown, but it is a most important one, namely that of going deep enough for excision of carcinomas of the face. Most surgeons excise widely enough, but many recurrences are caused by too shallow dissection. The ulcerating type of basal cell carcinoma is a notorious excavator, and of course the proclivities of squamous cell carcinoma are well known.

Case 6 is that of a 45 year old man. The basal cell lesion of his left cheek, treated three times with roentgen rays and radium, had recurred each time. Excision was rather wide, but complete undercutting of the surrounding tissue enabled a local closure to be made.

Case 7 is that of an 82 year old man with a basal cell lesion of five years' duration. It was luckily of the hypertrophic rather than the ulcerative type, but it measured 2 inches by $1\frac{5}{8}$ inches in area. Nevertheless, because elderly skin is looser and stretches much easier, the area could be closed primarily.

Case 8 illustrates one of the favorite plastic principles applied to large scars or hemangiomas. This principle concerns the use of multiple small excisions where a large excision would necessitate grafting and would detract from the cosmetic result to be obtained by removal of the scar or hemangioma. This method of course is not to be applied in the case of malignant or premalignant lesions, nor do I believe it is a safe procedure in removal of nevi.

The patient in this case was a Negro boy 9 years of age, who had suffered a third degree burn of the scalp several years previously with scar formation. Excision was made in several stages allowing several months between stages, and he eventually attained an excellent result.

Conclusion

This paper has been presented in an effort to describe some of the principles underlying the specialty of plastic surgery.

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Discussion

DR. WALTER A. COAKLEY, Brooklyn: I am particularly delighted to see the title of this paper, "Principles of Plastic Surgery." The title, plastic surgeon, carries a rather unpleasant connotation. Most of us do not like to be called plastic surgeons, but would prefer reconstructive surgeons. The term, plastic surgeon, connotes to many a fellow who trims a nose because a woman does not like its shape, or thinks she does not. We are primarily interested in the restoration of function, and also from the aesthetic standpoint we like to improve appearance when possible as well as restore function.

We do not like to make unnecessary scars. The first case which Dr. Robertson presented, the one in which the zygomatic arch was fractured and depressed, is an illustration that shows the incision having been made in the hair line and carried through the temporal fascia to the muscle fibers. In this procedure we not only think of the prevention of scar but of easy access to the fracture. An elevator is dropped between the temporal fascia and the muscle, and the lower end is engaged behind the fractured bone, which is lifted into place. There is here combined scar prevention with easiness of approach.

The next case which the essayist presented was a most difficult one. The patient was badly burned, and it was necessary to reconstruct the eye socket and the eyelids and much of the face. While he was my resident, Dr. Robertson did all this work. Since Dr. Robertson has left me, the patient has undergone two more operations, and his appearance with the prosthesis in place in the right orbital cavity is much better than the most recent pictures shown here.

To get back to the principles of plastic surgery, we believe that general surgical training is absolutely necessary in the training of good plastic surgeons. We believe so strongly in this that applicants for the American Board of Plastic Surgery must have two years of postgraduate general surgical training before a residency in plastic surgery to become eligible to take the board examinations. We believe the best plastic surgery is done by those men who have had good general surgical training. We believe any good surgeon would make a good plastic surgeon if he had the time to devote to it.

I believe that Dr. Robertson has about scotched the impression that has gone around the country that a plastic surgeon is necessarily a sculptor and artist, or one who has special gifts. This is absolutely untrue. These gifts, however, help those who have them. I have as assistants two artists and sculptors who do beautiful work, and it is, as I have said before, fine to have these abilities, but is not absolutely necessary.

In the case Dr. Robertson presented of a contracted scar which illustrated the breaking up of a straight line of scar by sewing the long line and creating diagonal scars, unfortunately, the intern who took the picture did not get proper exposure. It was a little bit dull.

The burned face illustrated the type of burns one sees in a large hospital—the completely carbonized tissues as they appear after they strike a high tension wire; and when I tell you that the heat generated in contact with a high tension wire or rail is approximately 1200 F. greater than the heat generated at the point of contact with an acetylene blow torch, you can understand what happens to the unfortunate victims who survive high tension wire contact.

Dr. Robertson has shown a large variety of cases, and I think he has demonstrated that plastic surgery is something more than beauty surgery and embraces something more than trimming down a nose or removing scars from vain people.

I want to thank Dr. Robertson for giving me this opportunity to discuss his paper, and the members of this society for listening to me.

The Planned Parenthood Program

D. F. MILAM, M.D.
NEW YORK

I welcome the opportunity to tell this Society something about the Planned Parenthood Federation of America, its organization, its work, its accomplishments, and the future needs and developments as I see them.

The Planned Parenthood Federation

The Planned Parenthood movement was first organized in 1921 as the American Birth Control League. Its name was changed in 1939 to the Birth Control Federation of America. In 1941 the Planned Parenthood Federation of America was organized to consolidate this organization with the Sanger Research Bureau and the name "Planned Parenthood" was selected as more descriptive of the actual program. The aim of the Federation has always been to give that national unity and local support which every movement needs if it is to take advantage of the opportunities for pushing ahead the whole program of which each local group or organization is an important link. The proverb "In unity there is strength" is highly applicable here. And to paraphrase Burke: When the opposition organizes, the good must associate. Our supporters believe that the program of Planned Parenthood is good for the individual, for the family, for the community, for the nation, and for the world. In its largest aspect, the stabilization of national populations goes to the root of most of the conflicts that harass the nations of this troubled world.

At present the Planned Parenthood Federation of America is a federation of 129 local associations or committees operating 151 clinics in 29 states. In 15 states the Planned Parenthood associations are organized into state leagues. All of these groups are carrying on the two chief items in the Federation's program: first, the offering of direct aid and advice to the individuals needing family plan-

ning for family solidarity; and secondly, a general educational program to convince the public that this program is necessary for stable family life and intelligent parenthood. The urgent importance of population control for world stability also plays some part in this public education program.

In addition to the clinics of the Planned Parenthood organization, there are more than 250 clinics in public health departments and an additional number in hospitals throughout the country.

Program

I should like to state at this point that this program of planned parenthood in the United States is not a "no babies" program, and not necessarily one for limitation of family size. The main idea is for each family to plan the time of arrival of its children in accordance with the mother's health and strength, the family's economic status, and the parents' wish to give to each of the children the love and care and training that will turn them all into useful and constructive citizens. The wanted child is the aim, and the avoidance of the unwanted child who is the source of so many unlovely features of our national and family life. Within this program the large family of children, for parents wanting them and able to care for them, is highly acceptable. The houseful of children in "Cheaper by the Dozen" fits well into this picture of wanted children. But we would question the rightness of the ailing mother bringing forth a succession of ailing infants to sap her inadequate strength and die in infancy from accumulated inadequacies and familial diseases. Nor could we say much for the family on public relief for fifteen or twenty years presenting the community with a new baby every year or two as an additional burden on public relief funds. These two conditions do recur, over and over.

In the absence of public provision for this need

National Director, The Planned Parenthood Federation of America.

Read before the Florida Health Officers' Society, Fifth Annual Meeting, Hollywood, April 23, 1950.

for family planning, a few persons started a program some thirty years ago, to arouse the public to its basic need, and to start providing its benefits as far as the private funds they could muster would make possible. The devotion of these early pioneers to a program misunderstood by the public is a most stimulating picture of what the human spirit can achieve. I do not need to tell you that this devotion is still needed in a very definite way. The opponents of this program are active and well organized. If family planning is to succeed and to reach those needing it, a great development of facilities providing it will have to take place.

The progress of man's control of his environment is a magnificent story. The most important item in all his environment is his own numbers. To draw a line here and to hold that man is forbidden to use his intelligence and his reason on this most important item of his environment, his own fertility, is to deny the validity of man's use of his intelligence for his own welfare. A large percentage of the great religious leaders of America accept this program of family planning as basic to family solidarity and welfare, in a rapidly changing world in this most trying of ages. We like to believe that all groups will eventually, and soon, arrive at the same conclusion. In the meantime the good fight must continue.

For the physician, it is a fight which he wages on behalf of his patients. This is so well recognized that most of our medical schools now include instruction in conception control in their curricula. Conception control is a tool for the doctor in his private practice and in public health. Most physicians have had their own experience of its value. When Dr. Alan F. Guttmacher of Johns Hopkins took a sampling of 3,381 physicians all across the country, he found that at least 93 per cent of them were asked about conception control by their patients, and nearly two thirds of them reported that these requests were frequent. But it is not enough to wait until the patient asks. Many will be shy about discussing such an intimate problem even with their physician, and many will not know there is anything he can do to help them. These patients usually are the ones most in need of advice. It is, therefore, frequently the physician's responsibility to raise the question himself when in his opinion conception control is indicated. It is interesting to note that in Dr. Guttmacher's survey, nearly 98 per cent of the physicians re-

ported their belief that conception control is indicated in some cases, 86.5 per cent of them believing in it for reasons of child-spacing.

When it comes to the public health services, the place of conception control as standard practice needs widespread acceptance. The clients of the public health department usually do not have the benefit of the advice of a private physician. Yet in this group, health and family security are more likely to be threatened by too frequent or ill-timed pregnancies. This observation is not just theory. Experience shows the practical advantages of conception control as an integral part of public health service. Not only is family planning of great importance for its own sake, but it has proved to be an invaluable weapon in combating some of our chief health hazards.

This fact is attested, for example, by Dr. Felix J. Underwood, executive officer of the Mississippi State Board of Health. After operating conception control as a part of his state's maternity and infant service for five years, he declared that it "has an important function to play in at least four other programs in which our health departments are participating." Dr. Underwood listed the four as tuberculosis control, cancer control, mental hygiene and venereal disease, and he added: "A public health program which today attempts to face these problems without the very vital aid and assistance which it may receive from a Planned Parenthood program is handicapping itself." No maternal hygiene program is adequate unless it provides conception control services for its clients.

Other Items in a Planned Parenthood Program

1. INFERTILITY. — Here I should like to mention, briefly, some important activities Planned Parenthood carries on in addition to the two chief items mentioned previously. If a couple is childless and wants children, theirs is a problem for Planned Parenthood, and an appealing one. Diagnostic work is done to plan a pregnancy. Where our clinics have facilities for the highly specialized service of testing these couples and bringing relief to the appreciable percentage that can be benefited, it is being done under Planned Parenthood auspices as a clinic service. There are 16 in the United States. Elsewhere our groups maintain a system of referrals to private physicians better equipped for this service. The provision of this service is a most natural activity for a Planned Parenthood program. It is, however, not of equal

importance with the basic aim of providing conception control service to those needing it.

2. EDUCATION AND PREPARATION FOR MARRIAGE AND PARENTHOOD.—This activity is closely connected with a program of family planning for stable family life. The complexity of the matter and the many disciplines involved in an adequate program of counseling have resulted in a chary approach to this matter in most of our local committees. Where it is carried out in a Planned Parenthood clinic, the emphasis is on the biologic aspects of the problem. In several large cities excellent programs are under way in Planned Parenthood clinics, with trained psychiatric guidance. Sometimes the group conference is used to carry out a more extensive service. The Medical Committee of the Planned Parenthood Federation, with expert assistance from other specialties, has recently prepared a "Standards" for the guidance of local committees. Not a major activity, this education for marriage and parenthood is nevertheless a most important one. Smaller clinics frequently conduct a referral service only. Others take part in cooperative services offered by a number of agencies in the community.

3. RESEARCH.—Another item in the Planned Parenthood program is the fostering of research, both basic and applied, on the problems of human fertility. This is a must, especially when we consider the urgent need for better contraceptive methods. The physiology of human reproduction is being intensely studied in many places, chiefly in the medical faculties of universities. The Planned Parenthood Federation is financing a small number of these studies on basic problems, and would like to be able to finance many more. Some one of the many researches now under way may suddenly solve the basic riddle and open the way for a more direct approach to control. Present methods of conception control are inadequate and cumbersome. They are totally inapplicable to much of the world's population, especially in the overpopulated and poverty-stricken areas where it is most needed. There are well founded hopes that better methods are just around the corner, and the ideal method is not excluded from this possibility. Large sums are being spent on applied and basic research into this problem of better contraceptives, but, quite evidently, not enough. Man has solved scientific problems of equal complexity, and is likely to solve this one, too. But in the meantime, we must carry on with what we have.

Methods in Use

May I say a few words about the methods in use today and mention the hopes for better things to come? As you well know, the method now recommended in all the Planned Parenthood clinics is the cervical diaphragm plus a spermicidal jelly. This is the most reliable method, at present, of the methods the woman herself can apply, and only the most reliable is acceptable when the need for control is urgent. There are other good methods apparently of lesser efficiency but still valuable. The use of spermicidal jelly alone is being tested in rural areas in two states under the State Boards of Health and Planned Parenthood Federation auspices, with promising results to date. When the diaphragm is too complicated a procedure, this method should certainly be next in line. It is apparently more efficient than the sponge and foam powder method. Two highly efficient methods, the condom and periodic continence, are adaptable to certain groups, but our practical problem lies with the woman who must herself take the precautions that will let her plan the time of arrival of her children. Suppositories and a new spermicidal tablet are being tried out and may result in an improvement of present technics.

The booklet by Robert Latou Dickinson, M.D., entitled "Techniques of Conception Control," is available. It gives considerable information on Planned Parenthood.

All these methods are of little use in the greatly overpopulated areas with an abjectly poor population, where a mounting population means misery for the masses, and where relief comes only from the natural controls like starvation and disease, or the more vigorous personal attempts, like abortion, infanticide or war. China today is an example of overpopulation. Wars we still have and they are basically traceable to this cause of overpopulation in relation to national resources. A squandering of these resources has given us, through our prophets of doom, a frightening picture of the future. We cannot brush this off with some pious hopes urging better agricultural methods or generalized industrialization as a cure-all. The menace is here and it is real. That it does not immediately touch our own great nation with its rich patrimony of resources is small excuse for complacency. We have recently learned, the hard way, that the world of mankind is a unit and a cancer in one part will affect the whole body. We in the United States cannot ignore the overpopu-

lated regions of the world. They can bring us all down in their own misery. A contraceptive that is cheap, reliable, acceptable, which could be given wholesale use in these overpopulated areas, would be a leading factor in guiding the world back to the ways of peace. There are some heartening indications that such a contraceptive is on the way. But much costly research may still be necessary before it is ready.

And now just one dip into scientific fantasy. The ideal method of conception control would be some simple method of diagnosing the time of ovulation, some method as easily applied as the litmus paper test for acidity. There are known to be definite changes that take place during the few days or rather hours of the ovulation period. The temperature change is well known, but attempts to use this as a guide to the safe period have been disappointing as a widespread practical procedure. It has its merits for a limited group. Possibly the chemical change in the composition of cervical mucus may offer a lead, and this is being intensely studied. The glands of internal secretion are being studied also in this connection, and a most complicated, involved picture it is. But there is the hope that this question can be solved, and that families can be planned with certainty with the cost being only the requirement of a few days continence each month, maybe only three. That would be the best solution.

The possibility of injection of some glandular extract which would produce a period of absolute infertility of lengthy duration, such a day dream is most appealing, but is still a day dream only. It is not outside the realm of possibility, but the highly complicated factors surrounding the effects

of hormones make it improbable from our present viewpoint. An immense program of basic research is called for, and indications are that this is being realized where realization counts.

Conclusion

And so we come back to our thesis that for the present we must go ahead with the methods we have. The need is too urgent to hold back for the better methods we hope are coming.

At the heart of the applied program of conception control is the physician. His responsibilities in this regard are enormous. Not only must he apply known methods for the benefit of his patients, but from his leadership in this health program, he must sponsor control as a health measure if it is to get the needed popular support. This support must sometimes be given by the physician at considerable personal hazard to his career or his financial success. But there is a stiff body of lay opinion and there are many lay workers who are backing him up in his attitude of support for a conception control program. The program is one which has enlisted the loyalty and support of many men and women of good will, who are interested in humanity and its fate. Many of the outstanding religious leaders of America, who are interested in the stability of the family and of the nation, see in this program a basic pillar to our survival. There are spiritual overtones in this basic family need to control human reproduction, and many religious leaders have had the insight to realize their presence. There is need that physicians be equally intelligent and courageous in formulating their attitudes and actions.

501 Madison Avenue.

Members of the Association who desire space for Scientific Exhibits at the Seventy-Seventh annual meeting in Hollywood, April 22-25, are requested to write Box 1018, Jacksonville, without delay.

Pneumoperitoneum in the Treatment of Pulmonary Tuberculosis

JOHN A. BARGER, JR., M.D.

AND

PETER FELOS, M.D.

TAMPA

Of the many methods of treating pulmonary tuberculosis that have been used in the past by various individuals, groups and sanatoriums, some have been dropped from the armamentarium and others continued, all depending upon the final results obtained. One must not be too enthusiastic for one method or another, without considering the individual intrinsic factors that influence the course and outcome of the disease. One method alone could be misinterpreted as taking all the credit for the benefit and improvement to the exclusion and value of other types of therapy. Pneumoperitoneum does not cure in all cases of pulmonary tuberculosis. This method was suggested by Banyai¹ in 1931 and first used for treatment by Vajda² in 1933. It has been used with a great deal of success on approximately 550 patients at the Southwest Florida State Sanatorium since it was opened in 1946.

Indications for Use

We have found to attain this degree of arrest certain basic factors, enumerated and discussed here, must be considered in the successful treatment of pulmonary tuberculosis with pneumoperitoneum. Like other collapse procedures it has its indications as well as limitation. We find the indications for this treatment are broad, and if other types of collapse or relax therapy are not successful or are contraindicated, one should give pneumoperitoneum a trial. We do not, however, believe in this method as a last resort, but think it should be used more frequently as a primary procedure. Then if after a period of observation it proves ineffective and there is no improvement, this therapy should be discontinued.

The location of the disease or sites of lesions in the lung we do not consider as important as

do some clinicians using pneumoperitoneum in apical, middle or lower lobe pulmonary tuberculosis. The course and prognosis are such, as we all know, that one can never accurately predict the degree of success that may be obtained by any one method. It is our idea from observation that pneumoperitoneum may prevent spread and keep arrested or cure any small or apparent active foci in the good lung. This agrees with the ideas of some of the thoracic surgeons on the preparation of the patient for surgery.

In far advanced cases this can be given a trial, when any other type of collapse would be impossible. Any pulmonary hemorrhage is serious because of the relationship to the activity of the disease. Frequently prompt institution of pneumoperitoneum may help decrease the amount of and in some cases stop the hemorrhage. Pneumoperitoneum causes a reduction in pulmonary volume in ambulatory patients that is complementary to recumbency without collapse. This decrease in vital capacity helps in some cases to keep the patient from being too active.

Technic

The technic of giving pneumoperitoneum is relatively simple and has been adequately described by many physicians. The location for inserting the needle as well as the use of local anesthesia depends upon training and upon regional and individual preference. We use 1 per cent novocain and inject a small wheal in the skin, then anesthetize the deeper tissues through the same site using a 26 gage 1 inch needle, then taking an 18 gage 3 inch needle to go into the peritoneal space.

The amount of air given each time, especially on initial and subsequent refills, is dependent upon adequate rise of the diaphragm or immobilization of the lung.

Read before the Florida Chapter, American College of Chest Physicians, Second Annual Meeting, Hollywood, April 23, 1950.

We find the time interval on initial refills is relative, and much depends on the patient's tolerance and reaction to this treatment. Usually it is a two to three day interval; yet, we find in some cases a weekly refill will suffice, with increasing amounts of air given each time until the desired degree of immobilization is established. At this time we take a roentgenogram for record to show what has been accomplished.

Again we repeat that training, experience and consideration of the patient help us to decide what course to follow. One must remember that pneumoperitoneum extends pressure on many vital organs; so the gradual establishment will do much for the physical as well as the mental comfort of the patient.

The barometric pressure and temperature should be considered, especially so in regard to travel and altitude. The degree of immobilization depends upon what can be accomplished without atelectasis of any part of the lung tissue.

We follow the rule never to raise the diaphragm above the lung root, preferably one rib interspace below. The pressure readings are relative, and the degree of immobilization or collapse can not be predicted as with pneumothorax. For that reason we use quantities of air as a measure to guide us with periodic fluoroscopic examinations and roentgenograms to inform us if we need to increase or decrease the quantity of air on refills. After the degree of immobilization of lung tissue has been determined, it is easy to arrange time and quantities of air necessary to maintain the same constant degree of immobilization. This varies from seven to ten days and in some cases longer.

We do not use abdominal binders routinely; it is our observation they benefit only in cases of extremely relaxed abdominal walls. With increase in weight of some patients one frequently finds an increase in abdominal pressure. In this type of case, we give less air or increase the time interval of refills.

Without definite endobronchial disease, conversion of sputum and cavity closure apparently go together. These findings are variable, usually occurring in four to six months in cases in which there is satisfactory progress on this treatment. We maintain this same routine with only slight modification, such as increase in exercise, until the arrest we desire is attained, always remembering we are sacrificing the time elements for a safe easy method that in comparison with other collapse therapy is slow and frequently not as spectacular.

Phrenic crushes in combination with pneumoperitoneum have given us excellent results in those cases in which the rise of the diaphragm was inadequate to maintain the immobilization of the lung that we desired.

As for the antibiotic, dihydrostreptomycin, and the chemotherapeutic agents, para-aminosalicylate and tibione, we use them in combination with pneumoperitoneum, in the same manner as the thoracic surgeon does, believing collapse therapy can be instituted much sooner without the so-called cooling off period of the acute phase of tuberculosis and without the danger of the infectious material that may be squeezed from a diseased area infecting healthy normal lung tissue.

Bed rest is a fundamental basic principle in the treatment of pulmonary tuberculosis. When pneumoperitoneum and bed rest are combined in therapy, we evaluate the patient as a whole, taking into consideration laboratory and roentgen findings, particularly if a changing lesion is demonstrated, before permitting too much increase in exercise for the patient. It is easy to visualize that a relatively free lung is necessary to allow the maximum amount of immobilization. For this reason we find pneumonolysis in combination with pneumoperitoneum and pneumothorax most effective; combining these two procedures will in some cases change the angle and allow greater collapse.

Pneumoperitoneum has some definite advantages over pneumothorax. They are: (1) greater margin of safety; (2) the fact that it can be discontinued and reinstituted at will without any particular difficulty; and (3) fewer complications.

Complications

The complications of pneumoperitoneum are surprisingly few and as a rule not serious. In many instances they are of a temporary nature and do not interfere with treatment. The most frequent one is pain in the apical region of one or both lungs and the shoulder. This is almost always a transient complaint and in many instances is relieved with simple sedation; it usually disappears within a week or ten days. Pneumoperitoneum can be maintained with simple gastric sedation when nausea and vomiting occur unless there is an acute or chronic organic abdominal disease. We discontinue treatment for a number of conditions, some due to complications; others are such that treatment is ineffective. They include anorexia with progressive loss of weight, peritoni-

tis, chronic or acute abdominal disease, hernias when the amount of air given must be reduced so much that the amount of immobilization of the lung is negligible, rigid diaphragm, cardiac disease and mediastinal disease.

Analysis of Series

In our series of cases there were 2 deaths. Pneumoperitoneum was not, however, confirmed as the causative factor by autopsy. Since 1946 this therapy has been employed in 550 cases, and 18,780 treatments have been given.

We wish to emphasize that a great deal of controversy exists relative to the usefulness of pneumoperitoneum as a sound therapeutic procedure. We attribute this to (1) too few cases having been observed to give a comprehensive evaluation of this method, (2) lack of experience of some clini-

cians as to what to expect from pneumoperitoneum, and (3) pneumoperitoneum being a slow procedure and most periods of treatment too short.

Summary

A series of 550 cases of pulmonary tuberculosis in which pneumoperitoneum was used successfully in treatment is reported. The indications for the use of this method, the technic employed and the complications encountered are discussed.

The authors would like to thank Dr. Draper, Medical Director at Southwest Florida State Sanatorium, for his inspiration and assistance; also Doctors Nesbitt, Webster and White for their timely suggestions.

Southwest Florida State Sanatorium.

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ABSTRACTS OF MEDICAL ARTICLES

CEREBRAL ANGIOGRAPHY IN "BRAIN TUMOR SUSPECTS." By George G. Culbreth, M.D., A. Earl Walker, M.D., and Robert W. Curry, M.D. *J. Neurosurg.* 7:127-138 (March) 1950.

This study, reporting angiographic findings in a consecutive series of "brain tumor suspects" seen at the Johns Hopkins Hospital during a period of approximately one year, indicates the value of angiography both in localizing the site of a tumor and in indicating its probable pathologic structure. Some 96 "brain tumor suspects" were subjected to angiography; in 3 cases the roentgenograms were technically unsatisfactory. Air studies or the course of the disease verified the diagnosis in all but 5 cases. In the group of 42 verified brain tumors, with 3 exceptions, the angiograms were interpreted as correctly localizing the lesion. Tumors of the medial part of the temporal lobe and the midline structures failed to visualize by angiography.

The angiographic appearance characterizing arteriovenous angiomas, glioblastomas, astrocytomas and meningiomas is described. The authors conclude that angiograms aid in the planning of surgical removal of the tumors and give information which may prevent surgical disasters.

CARCINOMA OF THE CERVIX. By J. H. Randall, M.D., W. C. Keettel, M.D., H. C. Willumsen, M.D., and J. W. Scott, M.D. *Am. J. Obst. & Gynec.* 59:285-295 (Feb.) 1950.

This study presents an analysis of the results from irradiation therapy in 983 patients with cervical carcinoma treated at the University of Iowa Hospitals between July 1926 and September 1942. The absolute five year survival rate for the entire period was 30.4 per cent; for 1926 to 1937, 25.7 per cent; but for 1937 to 1942, 37.0 per cent. Improvement in technic through the years brought great improvement in end results.

It was concluded that the stage of the disease is the most important single factor in end results, that the histologic character of epidermoid carcinomas has little effect upon final results, and that patients who are young or senile and those who are febrile or have an inverting type of growth generally respond less well to irradiation. The authors stated that complications are inevitable when irradiation is given to the limits of tolerance and added that there is a definite primary mortality of 1 to 2 per cent from irradiation treatment of cervical cancer to the point of tissue tolerance.

THORACOPAGUS TWINS: PRENATAL DIAGNOSIS.

By Charles M. Gray, M.D., H. G. Nix, M.D., and A. J. Wallace, M.D. *Radiology* 54:398-399 (March) 1950.

A case is reported in which a prenatal roentgen diagnosis of thoracopagus twins was made on the following points: (1) Both fetal heads were at the same level and in the same plane. (2) There was an unusual backward flexion of the cervical spines. (3) The extremely narrow space between the lower cervical and upper thoracic spines was much too narrow for the presence of normally developed thoracic cages. (4) There was no change in the relative positions after a week of maternal movement nor with manual manipulation at the time of the second roentgen examination.

The authors stressed the importance of recognition of this anomaly so that the obstetrician may be warned of the problem with which he will be faced. They found, however, but 1 case in the literature in which a roentgen diagnosis of conjoined twins was made before delivery and through personal correspondence they learned of 2 additional cases.



THIAMINE CHLORIDE AND NEOSTIGMINE BROMIDE FOR THE TREATMENT OF ANGINA PECTORIS.

By N. Stuart Gilbert, M.D. *Medical Record* (Feb.) 1949.

A preliminary report is presented of a series of 19 cases in which patients with cardiac disease and angina were treated by the combined use of thiamine chloride and neostigmine bromide. The relief was rapid and dramatic in every instance, and the author hopes that further study will substantiate the preliminary work.

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Vivisection

Significant achievements against antivivisectionists have been made by local groups during the last two years. While state level legislation has been stalled in Illinois, Massachusetts, New York, Pennsylvania and Oklahoma, municipal action has been successful in Baltimore, Buffalo, Denver, Los Angeles and Omaha, and in four suburban communities in New York. Campaigns in these cities and suburban communities have forestalled antivivisection legislation and have served to educate the public, impress legislators and give medical scientists experience for future action.

Immediately after passage of an ordinance in Baltimore permitting animal research, the antivivisectionists set out to nullify the law by referendum. A whirlwind campaign to obtain 50,000 names on their petition netted less than 20,000. Physicians, backed by the Baltimore Animal Aid Association, the Baltimore Beagle Club and the Lions Club, launched a spirited, sparkling campaign. At a public hearing the antivivisectionists were challenged to choose between a child and a mongrel stray dog. The little child had been saved through surgery perfected upon dogs. Many wild-eyed, irresponsible and narrowly prejudiced agitators hissed the child and cheered the dog. When challenged to show how medical science could advance without animal experimentation, some antivivisectionists suggested that waterfront bums, prisoners in jails and inmates of insane asylums be used.

The campaign boiled for months, arousing Baltimoreans to a fever pitch. At the polls in Baltimore on November 7, a large majority of the people voted to permit continued scientific research upon animals. The vote, 160,264 to 38,445, was more than four to one.

Los Angeles, when confronted with a similar referendum, also faced shenanigans from screw ball agitators. The November-December Bulletin of the National Society for Medical Research shows a revealing photograph wherein strange-looking women with fanatical gleam in the eye struggle for the microphone at a Los Angeles hearing in a determined effort to say their pieces against vivisection. Fake pictures of animal torture and gruesome tales about doctors were circulated. Cheap literature called medical researchers "fiends," "ghouls," "sadists" and "murderers." The Los Angeles vote on November 7 was: in favor of using stray dogs and cats for research, 357,393, and against, 261,699.

Buffalo medical scientists had their troubles, also. During six months of fighting to implement the Council's decision to save animals for medical study, their support grew by leaps and bounds. The original councilmanic vote of 11 to 4 increased to 15 to 0 by the time final legislative steps were taken. This vote was achieved in the face of the refusal of the Society for the Prevention of Cruelty to Animals to save unclaimed animals for research and in spite of the mayor's repeated vetoes.

Time, in its November 20 issue, caught the spirit of the problem and went to the core of the solution. A smiling small boy whose life was saved in Baltimore by advanced cardiac surgery is shown holding a dog which helped save his life. This dog, now a laboratory pet, had the same type of operation performed upon him three and a half years before when that type of surgery was being perfected. *Time's* article is captioned "Man or Dog?"

Medical research on animals is a more critical issue than most physicians realize. The anti-vivisectionists would tie the hands of medical researchers and they will go to almost any length to obtain their objective. William Randolph Hearst is sponsoring this fanatical cult.

There are some health workers and organizations, even an occasional county medical society, which will not take an open stand upon this issue. It is now high time that physicians and other health workers come out squarely for research upon animals and, profiting by lessons learned at the city and community levels, make the issue statewide and nationwide.

The Universal Language of Medicine

In the light of the highly critical world situation at this time, it seems obvious that this country must build the "garrison state" if it is to survive. Leaders place more and more emphasis upon armaments and on propaganda warfare, and well they may. But neither gun powder nor lung power alone will enable us to build a free world. Adequate strength for this immense task will come only from our dedicated resolve to help all peoples to find a better life. As a people we have become convinced that our gospel of human freedom and political equality can be made to reach and to bring fresh hope to all men everywhere. Perhaps we lose sight, however, of the fact that peoples accustomed to exist on a subhuman standard of living find little appeal in a concept of "freedom," the meaning of which they do not grasp.

"A better life for all people everywhere" is indeed a fundamental goal which will make for true global strength. In the nurture of worldwide human welfare, which is the avowed purpose of this country and the United Nations, a source of strength throughout the world which is not to be overlooked may be found in the universal language of medicine.

As amply demonstrated in the Fourth General Assembly of the World Medical Association held

in New York last October, physicians by their thinking, spirit and effort "can set an example for government, diplomats and people everywhere." The evidences of friendliness, understanding and cooperation at this meeting vied with the scientific contributions as the most notable feature of the gathering. They proved conclusively that physicians from all over the world, if given the opportunity, can meet harmoniously and exchange health information for the good of the whole world.

There were in attendance official representatives from 29 of the 39 member nations and also many foreign visitors despite the difficulties of travel from many countries today. Their presence and interest gave proof of their willingness to align themselves with their colleagues in "an unbreakable line of offense against disease." The two new members elected were the National Medical Associations of Ethiopia and Thailand.

The importance of health to peace was clearly emphasized in this meeting. Without it no nation can prosper. With it any nation has a commanding asset. Upon assuming the presidency of this organization, Dr. Elmer L. Henderson, currently also president of the American Medical Association, called on physicians the world over to "demonstrate convincingly that international cooperation is a workable reality . . . and prove that men can work together for self improvement and the benefit of humanity — regardless of differences in nationality, race, creed, or political philosophy." This assembly, the one next September in Stockholm and succeeding assemblies of the World Medical Association offer much hope for the future.

The Good Old Days

Remember 'way back in 1901 when ham was a dime a pound, folks were dancing the cakewalk, and the horse and buggy held sway? Those were "the good old days." Perennially with the coming of the New Year, there are those who indulge in nostalgic longing for the yesteryears of fond memory.

Looking back an even half century, one finds President McKinley in the White House, Queen Victoria on England's throne, Kaiser Wilhelm II occupying Germany's imperial throne, and Dowager Queen Wilhelmina of the Netherlands a bride. In China, the various world powers ended the anti-European, anti-United States Boxer Rebellion, and United States troops were cleaning out

nest of die-hards in the Philippines as an aftermath of the Spanish-American War.

In a prophetic New Year's Eve toast, Senator Albert J. Beveridge proclaimed the new twentieth century the United States century, a new golden age, declaring, "American thought will dominate it . . . American progress will give it color and direction . . . American deeds will make it illustrious." The United States was fast becoming the richest nation in the world. The Congress passed the second billion dollar budget, and the national debt was a mere \$14.89 per person. The country had a population of 76,100,000 at that time, with New York, Chicago and Philadelphia alone each claiming more than 1,000,000. A mere whistle-stop, Los Angeles had but 50,000 and not a single motion picture theater.

Women were resplendent in leg o' mutton sleeves, choker collars, black stockings and sixteen button shoes; and milady's mink cape cost a mere \$160. As for male dandies, they were handsomely attired in fancy waistcoats, celluloid collars, derbies, and spats over high top shoes. Men's Chesterfield overcoats cost \$12.50. Stogies were the vogue for gentlemen; cigarette smoking and wrist watch wearing were sissified.

Fashionable seven room apartments in one big city were going begging at \$37 a month, and a five-bedroom house with plumbing and gas, and even an electric doorbell, could be built for \$2,200. One of those new talking gadgets, a telephone, was available at a cost of 16 cents a day. Incomes of course matched prices, and sixty to seventy hour work weeks were more the rule than the exception.

Red and green rosamond jars in the show windows identified the up-to-date pharmacy. Sulfur, molasses and sassafras were standard remedies, and the candy department consisted of a few plain glass jars of horehound and mint drops. Registered pharmacists received as high as \$70 a month, and a bill before one legislature proposed to limit pharmacists to a seventy hour week.

It was in 1901 that Landsteiner discovered the human blood groups. The Army Nurse Corps was founded that year. Four years later, the American Medical Association established its Council on Pharmacy and Medicine. Only three years earlier, the Curies had discovered radium, bringing in its wake knowledge of the behavior of the atom, and, in turn, atomic fission which made possible today's atomic bomb.

Astrologers, predicting dire events that did not happen, failed to forecast the \$10,000,000 fire of May 3 which devastated Jacksonville. That city, in its Fifty Years of Progress celebration this year, will portray its rise across half a century following that disaster.

As waltzers swayed to the day's top tune, "In the Good Old Summertime," a new era was dawning. The record for going around the world was sixty days, thirteen hours and fifty-five minutes, but the Wright brothers were putting the finishing touches on an airplane glider, and in December Marconi radioed the letter S across the Atlantic from England to Newfoundland.

Before the year was out, an anarchist's bullets claimed the life of President McKinley. Queen Victoria died. The famed Victorian Era was passing — making way for the predicted new golden age. That faster-paced Wonder Century is now half gone — and whither?

Advice to Parents —

Don't Dictate Your Child's Career

The family physician often has the role of family adviser on a broader plane than health. There is the all important matter of the choice of a career for this boy or that girl, the youth of today who represent the future of the nation. Sometimes, in the advice he gives on this problem, the doctor may well practice what he preaches.

Do you know a physician who should not be a doctor, who did not want to be, who would not have been except for a family tradition? He is only fairly successful, isn't he? And his friends say he has never been happy practicing medicine. Yes, he wanted to be a mechanical engineer. There were signals all along the way as the boy was growing up — a library filled with books on mechanics, a workshop in the basement, and the summer job in a garage. But how often parents prefer not to see such plain indications of their son's tastes.

All educators the country over relate that they find many parents, especially fathers, completely intolerant of their sons' preferences in choosing their life work. In any high school almost every senior class has students who are high-pressured by their parents into the selection of their life work. For example, there was a the boy, thrilled with the thought of his responsibility to humanity, who wanted to make research his life work, but driving a delivery truck for the dairy in which his father had worked up to assistant manager would bring,

with commissions, \$82 a week, or more than \$4,000 a year. Research would be a long time paying as much.

This determination of parents to select a career for their children grows even more oppressive in the college years. A distinguished university president was once asked which students he considered more harassed, those having a hard financial struggle or those struggling to make passing grades. He replied: "I would say that there is a group more harrassed than either of these—those young persons who are trying to fit themselves for the work their parents wish for them, irrespective of their qualifications." Doubtless no college lacks such a group. The career argument of a successful father is extremely difficult to combat. The banker's son who would enter the school of agriculture instead of the school of commerce is likely to encounter stiff opposition. Remember the eminent lawyer's son who, with his wife, would now be happy if only he were a carpenter instead of a lawyer?

Why do parents insist upon crippling their children's lives by dictating their careers? Do age and experience always give them wisdom to make the wisest choice? Physicians are often in a position to remind parents that the only way they can honestly qualify to guide and advise their children in the choice of their life's work is to study each child from infancy, sympathetically and continuously. Too many mothers and fathers need to realize that no man can make his best contribution unless he is doing the work he enjoys and for which he is best equipped physically, mentally and emotionally. Not through dictation, but through gentleness, understanding, alertness and direction across the years of childhood and youth can parents solve the riddle of their supreme duty—to help their children to the most satisfying life.

Midwinter Seminar in Ophthalmology and Otolaryngology

Miami Beach, January 15-20, 1951

The fifth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at Miami Beach again this year, beginning on January 15 and continuing through January 20. The lectures on Otolaryngology will be presented on January 15, 16 and 17, and those on Ophthalmology on January 18, 19 and 20.

Distinguished medical teachers who will lecture on Otolaryngology include Drs. Louis Clerf, Phila-

delphia; Gordon Hoople, Syracuse; D. M. Lierle, Iowa City; Benjamin Spector, Boston, and George Shambaugh, Chicago. Eminent lecturers on Ophthalmology include Drs. Conrad Berens, New York; Raymon Castroviejo, New York; Jack Guyton, Baltimore; Harold Scheie, Philadelphia, and Edmund Spaeth, Philadelphia.

On Wednesday, January 17, the Southern Section of the American Laryngological, Rhinological and Otological Society will convene for a one day session under the chairmanship of Dr. Charles C. Grace of St. Augustine. Dr. C. L. Jackson of Philadelphia will be among the speakers at this meeting.

The Florida Society of Ophthalmology and Otolaryngology will hold its annual midwinter convention concurrently with the Seminar, meeting on Wednesday night, January 17. The guest speakers on this occasion will be Drs. Berens and Shambaugh.

All of these meetings will be held in the new Sans Souci Hotel on the ocean front. The schedule will allow ample opportunity for enjoyment of the remarkable vacation facilities of Miami Beach.

Diabetes Seminar in Lakeland February 1 and 2, 1951

The date for the Diabetes Seminar, originally scheduled for January 25 and 26, has been changed to February 1 and 2. The place of the meeting this year is Lakeland.

Dr. H. B. Mulholland, Professor of Medicine at the University of Virginia Department of Medicine, Charlottesville, Va., and Dr. Philip K. Bondy, Department of Medicine, Emory University School of Medicine, Atlanta, Ga., comprise the faculty. The entire subject of diabetes in all its various aspects will be exceptionally well presented.

The general chairman in charge of local arrangements is Dr. Henry Fuller. The Polk County Medical Society is cooperating with him to make this meeting a big success.

The Seminar is presented by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association, the Florida State Board of Health and the American Diabetes Association. Physicians throughout the state are urged to attend.

Southeastern States Cancer Seminar Held

The Southeastern States Cancer Seminar closed its fourth annual meeting in Jacksonville on November 10 after again providing an unexcelled opportunity for graduate instruction in malignant disease. More than 600 physicians, surgeons and technicians from Georgia, South Carolina, Alabama, Mississippi, Florida and Cuba registered during the three day period.

The program had wide appeal to general practitioner and specialist alike, and the lectures were presented by some of the nation's most distinguished teachers in the various fields of cancer. The Duval County Medical Society, in charge of local arrangements, proved a gracious host to the hundreds of visiting physicians.

The Seminar is made possible annually by the Florida Division of the American Cancer Society and the Florida State Board of Health with the cooperation of the Florida Medical Association. The sponsoring agencies urge all physicians of the Southeastern area who are interested in cancer to plan now to attend these notable gatherings each fall. The prominence of the faculty and the urgency of the need for the widest possible dissemination of the latest information regarding malignant disease should draw a much larger attendance next year and from year to year as the members of the medical profession in this section of the nation come to appreciate more and more the value of this excellent graduate training conveniently provided for them.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

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Butter, John R., St. Petersburg
Cloud, Ishmail G., Lakeland
Lukens, Morris H. R., Orlando
Maybarduk, Alexander P., Orlando
Morris, Joseph H., Panama City
Regan, Joseph J., St. Petersburg
Schochet, Sydney S., Gainesville
Stevenson, Alfred S., Orlando
Summers, Paul L., Apopka
West, Joseph R., Palm Beach
Wilcox, Abbott Y., Jr., Bay Pines
Winslow, James A., Jr., Tampa

STATE BOARD OF HEALTH

Changes in the Cancer Control Program

Each physician in the State has been mailed a letter concerning the curtailment of funds available for health services in Florida. This cut in the over-all health program is due to the fact that the Federal Government reduced the amount of funds available to Florida in the amount of one hundred fifty thousand (\$150,000) for the period October 1, 1950 to June 30, 1951.

For the information of those physicians that did not see the letter sent out by the State Health Officer on October 23, 1950, it is being reproduced below:

The cancer load of patients has increased so rapidly in the last few months that it has become necessary for us to curtail certain parts of our cancer program. In addition to the heavy load of patients we have just received a large cut in federal funds for over-all health program. For these two reasons it is necessary for us to adopt the following measures concerning state aid to cover patients, effective immediately and applicable to all bills that have not already been processed for payment as of this date.

1. Hospitalization will be limited to fifteen days — No extensions.
2. Medical fees will be computed at one half the rate in the fee schedule.
3. Only cancer cases with the most favorable prognosis will be approved for state aid.
4. Requests for palliative therapy and emergency hospitalization of advanced cases will be rejected.
5. The state can be relieved of certain expenses such as transfusions, when the patient's family will make a sufficient number of donors available to replace the blood. No charge will be allowed for blood transfusions.
6. Cancer clinics must be utilized for diagnosis and recommendations in order to ascertain those cases most favorable for treatment. It may, however, be necessary to reject some cases approved by tumor clinics, if the funds within the month have been expended.
7. Those cases rejected must solicit help from other sources in the counties concerned.

We solicit your voluntary cooperation in the above recommendations. Beginning July 1, 1951, sufficient funds are anticipated to carry on again the cancer control program to the satisfaction of all.

It was necessary about 18 months ago to reduce the fee schedule for physicians' services. We have followed almost the same procedure as was followed at that time. The physicians of the State accepted this change as a rule without much criticism. The way the physicians accepted this change is certainly commendable. It is hoped that this further curtailment will be accepted also at this time. The State Health Department is using every effort to adjust its over-all program so as to render the best possible service it can with the funds that are available.

Poliomyelitis Isolation Period is Reduced

The State Board of Health in session recently in Jacksonville made the following amendments in Section 6, Paragraph 37, Page 46, of the Rules and Regulations for the Control of Communicable Diseases as Revised and Effective February 10, 1948.

The isolation period for poliomyelitis cases was reduced from a period of two weeks to "a period of one week from the date of onset or for the duration of fever if longer."

The isolation period on chickenpox is now "for six days after the appearance of the first group of vesicles."

These communicable diseases, as well as many other communicable diseases, are considered communicable a few days before the patient shows clinical symptoms of the disease. The control of poliomyelitis is most difficult from a public health viewpoint inasmuch as there are undoubtedly many cases of this disease that never develop clinical symptoms but at the same time are carriers of the disease.

Some thirty other state in the Union have adopted similar regulations to that of Florida insofar as the control of poliomyelitis is concerned.

YOUR BLUE SHIELD

Participating Physicians' Code Numbers

The Blue Shield Plan, in attempting to provide prompt and efficient service, has now undertaken a new method of payment to its participating physicians for services rendered.

Each participating physician has been given a statistical number, known as "Participating Physician's Code Number," and has been requested to have his secretary indicate that number next to his name on each Doctor's Service Report submitted.

This action is necessary due to the fact that there are now approximately 2300 participating physicians, many of whom have similar names. It is for this reason that payment in the past has occasionally been made incorrectly.

If each participating physician will instruct his secretary to make permanent record of this number and indicate it on each Service Report, more accurate payment can be assured by the Blue Shield Plan. If, at any time, the physician needs verification of this number, he should contact (Blue Shield) Florida Medical Service Corporation, Post Office Box 1798, Jacksonville 1, Florida.

STATE NEWS ITEMS

Miss Agnes Sawby and Dr. Herbert E. White, both of St. Augustine, were married on Nov. 18, 1950 at the home of Miss Sawby's sister, Mrs. Grice Blythman, in Maple Creek, Saskatchewan, Canada. The many friends of the couple throughout the state will receive this announcement with genuine interest.

Mrs. White has had a brilliant career in the field of dietetics. After receiving her BA degree at the University of Illinois, she served a dietetic internship at Michael Reese Hospital in Chicago and engaged in a research project in Ohio. She then organized the dietary department of St. Vincent's Hospital in Chicago and later served as therapeutic dietitian at Yale's New Haven Hospital, New Haven, Conn. In Florida, she came first to the Tampa Municipal Hospital in Tampa as chief dietitian. More than twelve years ago she became chief dietitian at Flagler Hospital in St. Augustine, where Dr. White has for many years been chief of staff. Mrs. White is a past president of the Florida Dietetics Association.

The members of the Florida Medical Association felicitate the Association's President and his bride.

Dr. Ralph S. Sappenfield of Miami was elected director of the American Society of Anesthesiologists at their meeting in Houston, Texas, November 7-10.

Dr. Howard G. Holland of Leesburg has been appointed by Governor Warren to the State Board of Medical Examiners for a four-year term. Dr. Holland previously served eight years on the Board under the administrations of Governors Holland and Caldwell.

Dr. Edith M. Corlew of Tampa was a guest speaker at a recent meeting of the local Business and Professional Woman's Club.

Dr. Amsie H. Lisenby of Panama City was the guest speaker at the West Florida druggists' convention held in Panama City in November.

Dr. William C. Williams, Jr., announces the removal of his offices from West Palm Beach to 11 S. E. Second Avenue, Delray Beach.

Association members registered at the recent meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago include: Drs. James W. Clower, Jr., and Eric H. Lenholt, Daytona Beach; Curtis D. Benton, Jr., and Garland M. Johnson, Ft. Lauderdale; Thomas M. Irwin, W. Jerome Knauer and G. Dekle Taylor, Jacksonville; Marion W. Hester, Lakeland; Nelson M. Black, Andrew G. Brown, George E. McKenzie and William Steinman, Miami; Francis E. Denman, Walter T. Hotchkiss, Samuel Kantor and Louis G. Lytton, Miami Beach; William H. Anderson, Jr., Ocala; Carl S. McLemore and Walton B. Wall, Jr., Orlando; Alan E. Bell and Mozart A. Lischkoff, Pensacola; Charles C. Grace, St. Augustine; Bernard T. Bell, Chester L. Goodnow and Paul T. Kope, St. Petersburg; Frederick D. Droegge, Sarasota; Edson J. Andrews, Tallahassee; R. Renfro Duke, J. Brown Farrior, Ned W. Holland, Blackburn W. Lowry and Anthony P. Perzia, Tampa, and Raymond R. Preefer, William Y. Sayad and Younger A. Staton, West Palm Beach.

Dr. Henry Fuller of Lakeland was a featured speaker at the semi-annual meeting of the Florida Division of the American Society of Medical Technologists, in Lakeland, November 11-12.

Dr. Edward R. Annis of Miami recently addressed the Miami Woman's Club on the subject, "American Medicine Serving Humanity."

Dr. John W. Williams of Lakeland served as a member of the forum on Parathion held by the Florida State Horticultural Society at Winter Haven, November 2.

Dr. Homer L. Pearson, Jr., of Miami on November 19 led a public forum discussion in the Rader Memorial Methodist Church on the subject of "The Issue of Compulsory Health Insurance."

Dr. Everett M. Harrison of Clearwater has returned to his practice following postgraduate work at the Cook County Graduate School of Medicine, Chicago.

Dr. Oren A. Ellingson of Tampa addressed the annual meeting of the Southern Medical Association held in St. Louis, November 13-16 on the subject, "Natural Childbirth."

Dr. James F. Speers of Titusville recently addressed the local Rotary Club on health problems.

Dr. George F. Schmitt of Miami has returned to his practice following a series of clinical observations of medical facilities in San Antonio, Fort Worth, Dallas, Oklahoma City, Kansas City, Chicago and Minneapolis. In conjunction with this tour he also attended a reunion of the Ex-Mayo fellows.

A report on medical society grievance committees has been prepared by the Council on Medical Service of the A.M.A. This report surveys the organization and operation of grievance committees on state and county levels throughout the nation. Copies of this report are available on request from the Council at 535 North Dearborn Street, Chicago 10, Illinois.

Dr. Homer L. Pearson, Jr., of Miami on November 9 addressed a joint meeting of the Hillsborough and Pinellas county medical societies in St. Petersburg on the subject, "A Physician's Obligation to His Community."

The following day Dr. Pearson addressed the St. Petersburg Rotary Club on "A Community's Obligation to Its Physician."

Dr. Frank M. Hall of Gainesville was elected vice-president of the health officers section at a recent meeting of the American Public Health Association in St. Louis.

Dr. John W. Williams of Lakeland served on a panel on Parathion Poisoning held by the Florida Industrial Commission at St. Petersburg, October 12, 1950.

Dr. Edgar E. Hitchcock of Orlando was elected president of the Florida State Pediatric Association at its fall conference held in Daytona Beach in November. Dr. Charlotte C. Maguire of Orlando was re-elected secretary-treasurer.

Dr. Edward R. Annis of Miami was one of the speakers at the 1950 annual meeting of the Association of American Physicians and Surgeons at Houston, Texas, October 5-7. Dr. Annis addressed the group on the part individual physicians should play in affairs of government.

Dr. Edward G. Haskell, Jr., of Branford was a guest speaker at a recent meeting of the local Kiwanis Club. Dr. Haskell gave information and statistics concerning venereal disease in this section of the state.

Dr. Frank G. Slaughter's latest venture in the literary field, a medical biography entitled, "Immortal Magyar," was recently released by the publishers.

"Immortal Magyar" is a vivid portrayal of the dramatic and tragic life of the Vienna physician, Ignaz Philipp Semmelweis (1818-1865). In a factual and interesting manner, Dr. Slaughter relates the difficulties encountered by the great Semmelweis in his attempt to save mothers and newborn babies from death by puerperal fever.

The fourteenth annual meeting of the New Orleans Graduate Medical Assembly has been scheduled for March 5-8 with headquarters at the Municipal Auditorium in New Orleans. In addition to an outstanding scientific program of interest to both specialist and general practitioner, there will be daily demonstrations of medical and surgical procedures in color television. Telecasts will be from the Charity Hospital to the Auditorium and are sponsored by Smith, Kline & French Laboratories.

On Saturday, March 10, following the 1951 meeting a postgraduate tour to Panama and sections of South America has been scheduled. Transportation will be by airplane from New Orleans to Panama. The itinerary also includes Medellin and Cali, Colombia; Quito, Ecuador and Lima, Peru. Medical programs and visits to hospitals have been arranged. The group will return to New Orleans on Sunday, March 25. For further information, write to the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

FOUND: One pair of prescription sunglasses left in the washroom of the Marion Hotel in Ocala during the medical district meeting. Owner is requested to contact Dr. Eugene G. Peek, Jr., Ocala.

WANTED: Physician either general practitioner or specialist. Air-conditioned office located on the south side of the St. Johns River. Community population, 70,000. For further information contact Dr. A. W. Sears, 2705 Atlantic Blvd., Jacksonville, Fla.

The Association's Scientific Work Committee held its final meeting in Jacksonville, December 10. The Scientific Program for the Association's Seventy-Seventh Annual Meeting in Hollywood next April was completed. Therefore no further applications can be considered.

Committee members present were: Drs. Frederick K. Herpel, Hardgrove S. Norris, Jere W. Annis and James L. Borland; Advisory, Stewart Thompson and Ernest Gibson.

Dr. Warren W. Quillian of Coral Gables was appointed by President White to represent the Florida Medical Association at the Mid-century White House Conference on children and youth in Washington, D. C., December 3-7.

Former Governor Millard F. Caldwell has been selected by President Truman to head the newly-formed Federal Civil Defense Agency.

The Federal Civil Defense Agency was set up by executive order in view of the critical international situation pending passage by the Congress of legislation dealing with the organization and administration of the civil defense program. Civil defense planning has previously been a function of the National Security Resources Board, headed by W. Stuart Symington. The new agency will be independent, responsible directly to President Truman.

The new Florida Medical Directory is scheduled for mailing in January. The price of the Directory is \$2.00. One free copy will be mailed to each member of the Association.

AVAILABLE: Office space formerly used by deceased general practitioner. Ideal location on ground floor, residential section, near business center. Agricultural community, 30-bed hospital. Write: Mrs. R. F. Godard, 310 W. Washington St., Quincy, Fla.

ASSOCIATION DESIRED: Ear, Nose and Throat specialist, 15 years' experience, refractions and minor eye work, American Board, wishes to associate with similar specialist. Prefer physician contemplating selling practice or retiring. Will consider sharing office with Internist, Pediatrician or Ophthalmologist. South Florida coast city preferred. Write 69-43, P. O. Box 1018, Jacksonville, Fla.

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Thirty-three members of the Association registered at the meeting of the Southern Medical Association held in St. Louis, November 14-16, 1950. They are: Drs. Richard C. Forman, Coral Gables; William D. Cawthon, DeFuniak Springs; Russell B. Carson, Ft. Lauderdale; William C. Thomas, Gainesville; Joseph M. Burton, Homestead; Simon E. Driskell, Thomas H. Lipscomb and James G. Lyerly, Jacksonville; Joseph L. Kinzie, Lake Wales; Albert E. McQuagge, Marianna; M. Jay Flipse, William M. Howdon, Leslie M. Jenkins, Walter C. Jones, Donald F. Marion, E. Sterling Nichol, J. Randolph Perdue, Gerard Raap, Bernard D. Ross, Wiley M. Sams and Donald W. Smith, Miami; Delmer J. Brown, Chas. J. Collins, John E. Crews, Don C. Robertson and Robert L. Tolle, Orlando; Wilton E. Tugwell, Pensacola; Orville L. Barks, Sanford; Odis G. Kendrick, Jr., Tallahassee, and Chadbourne A. Andrews, C. Frank Chunn, Oren A. Ellingson and Burdette Smith, Tampa.

The Southern Medical Association will meet in Dallas, Texas, November 5-8, 1951. Miami, Florida has been selected as the meeting place for 1952 on November 10-13.

Dr. Walter C. Jones of Miami was elected first vice-president of the Southern Medical Association at its annual meeting in St. Louis in November.

Dr. Chadbourne A. Andrews of Tampa has been appointed a member of the Council of the Southern Medical Association representing Florida. Dr. Andrews succeeds Dr. William C. Thomas of Gainesville, who, having served the constitutional limit, was not eligible for re-appointment.

Dr. Sullivan G. Bedell of Jacksonville was elected chairman of the section on Neurology and Psychiatry of the Southern Medical Association at its annual meeting in November.

Dr. J. Randolph Perdue of Miami was elected chairman of the section on Gynecology of the Southern Medical Association at its St. Louis meeting in November.

Dr. M. Jay Flipse of Miami was elected president of the American College of Chest Physicians, Southern Chapter, at its meeting in St. Louis in November.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Robert H. Nickau of Jacksonville announce the birth of a son, Douglas Alan, on Nov. 1, 1950.

Marriages

Dr. Herbert E. White and Miss Agnes L. Sawby, both of St. Augustine, were married on Nov. 18, 1950 in Maple Creek, Saskatchewan, Canada.

Deaths — Members

French, Elmo D., Miami	Oct. 24, 1950
Godard, Robert F., Quincy	Nov. 3, 1950
Drane, Miriam M., St. Petersburg	Nov. 28, 1950

Deaths — Other Doctors

Clark, Burton, Oshkosh, Wis.	Sept. 3, 1950
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COMPONENT SOCIETY NOTES

Columbia

The Columbia County Medical Society's annual dinner meeting was held in the Blanche Hotel, Lake City, on Monday, December 11. Dr. William C. Thomas of Gainesville, a past president of the Florida Medical Association, and Dr. Luther W. Holloway of Jacksonville were guest speakers. Dr. Robert B. Harkness was re-elected for a third term as president and Dr. Thomas H. Bates was re-elected secretary-treasurer for the twenty-fifth time. Dr. Laurie J. Arnold, Jr., was elected vice-president.

Marion

The Marion County Medical Society has announced the establishment of a grievance committee to hear and investigate complaints from the public against doctors of medicine.

Dr. Thos. H. Wallis has been appointed chairman of the committee. Other members are the four immediate past presidents of the society, Drs. Richard C. Cumming, Robert E. Thompson, Hugh H. Barfield and Henry L. Harrell.

Pinellas

The November meeting of the Pinellas County Medical Society was held at the Detroit Hotel in St. Petersburg on November 6. Dr. Daniel F. H. Murphey presented a paper on "A Case Report of Acute Leukemia in a Child of Ten Years Treated with Aminopterin and Cortisone," and Dr. Arthur Appleyard, Jr., presented a paper on "A Case Report on Severe Bullous Drug Eruption Treated with ACTH and Cortisone."

The Atlanta Graduate Medical Assembly

Municipal Auditorium Annex
Atlanta, Georgia

February 5, 6, 7, 1951

MONDAY — February 5

- 8:00 Registration
9:40 Dr. Fred W. Rankin: The Modern Management of Cancer of the Colon
10:05 Dr. Sara M. Jordan: Cancer of the Stomach
10:30 Dr. Waltman Walters: Cancer of the Stomach
10:55 Dr. T. Leon Howard: Tumors of the Upper Urinary Tract
11:20 Dr. Carleton B. Peirce, To be announced
11:45 Dr. Waltman Walters: Surgery of the Biliary Tract
12:10 Dr. George J. Thomas: Fire and Explosive Hazards in Hospitals
Lunch
2:00 Dr. John T. Godwin: Nevi and Melanoma
2:25 Dr. Fred W. Rankin: Modern Trends in the Management of Cancer of the Rectum
2:50 Dr. Grayson Carroll: Bacteriological Studies in Relation to Choice of Antibiotic Therapy
Review of Exhibits
3:35 Dr. F. William Sunderman: Laboratory Aids in the Management of the Surgical Patient
4:00 Drs. Jordan, Rankin, Walters and Peirce: Symposium — Cancer of the Stomach and Bowel
Dinner
8:00 Dr. George Van S. Smith: Functional Bleeding of the Endometrium
8:30 Dr. Winchell McK. Craig: The Importance of Intraspinal Lesions in General Diagnosis
9:00 Dr. Sara M. Jordan: The Management of Peptic Ulcer

TUESDAY — February 6

- 8:00 Dr. Warren W. Quillian: Care of the Premature Infant
8:25 Dr. John Parks: Urinary Tract Infections in Pregnancy
8:50 Dr. T. Leon Howard: Childhood Pathology of the Urinary Tract
9:15 Dr. Grayson Carroll: The Clinical Treatment of Urinary Infection
9:40 Dr. J. S. Speed: Minor Surgery of the Foot
Review of Exhibits
10:30 Dr. Richard B. Capps: The Diagnosis and Treatment of Chronic Hepatitis
10:55 Dr. John T. Godwin: Radiocautographic Localization and Pathological Effect of Iodine 131
11:20 Dr. Warren W. Quillian: Diarrhea in Children
11:45 Drs. Jordan, Walters and Capps: Symposium — Jaundice
Lunch
2:00 Dr. George Van S. Smith: Office Gynecology
2:25 Dr. John Parks: Placental Complications
2:50 Dr. George J. Thomas: Obstetrical Analgesia and Anesthesia
Review of Exhibits
Dr. Carleton B. Peirce: X-ray Treatment of Breast Cancer
4:00 Drs. Smith, Parks and Godwin: Symposium — Tumors of the Ovary
Reception

WEDNESDAY — February 7

- 8:00 Dr. Irvine H. Page: Diagnosis and Treatment of Hypertension
8:50 Dr. Winchell McK. Craig: The Relative Value of Surgery in the Treatment of Progressive Hypertension
9:15 Dr. Walter Bauer: Rheumatoid Arthritis, a Systemic Disease
Review of Exhibits
10:30 Dr. Richard B. Capps: Diagnosis and Treatment of Amebiasis and Amebic Hepatitis
10:55 Dr. F. William Sunderman: Some Clinical Aspects of Serum Electrolytes with Particular Reference to Sodium and Potassium
11:20 Dr. Samuel Proger: Obesity and Heart Failure
11:45 Drs. Craig, Page and Proger: Symposium — Hypertension
Lunch
2:00 Dr. John R. Mote: Newer Concepts Concerning the Role of the Adrenal Cortex in Health and Disease
2:55 Dr. J. S. Speed: Surgery in Chronic Rheumatoid Arthritis
Review of Exhibits
3:35 Dr. Samuel Proger: Coronary Insufficiency
4:00 Drs. Bauer, Speed, Proger and Mote: Symposium — ACTH

If you would like us to make your hotel reservation, may we suggest that you send your \$15.00 registration fee, payable to THE ATLANTA GRADUATE MEDICAL ASSEMBLY, to Mrs. Stewart R. Roberts, 768 Juniper St., N.E., Atlanta, Georgia.

OBITUARIES**Elmo Dial French**

Dr. Elmo D. French of Miami died of a heart attack on Oct. 24, 1950. He was 60 years of age. Interment took place in Lehighton, Pa.

Born in 1890, Dr. French received his medical training in Texas, where he was awarded the degree of Doctor of Medicine from the University of Texas Faculty of Medicine at Galveston in 1916.

He practiced in Jacksonville before locating in Miami in 1924. An outstanding dermatologist, he was active in the affairs of his community, was a Mason and a Rotarian, and was an elder in his church.

Dr. French was a member of the Dade County Medical Association, the Florida Medical Association and the American Academy of Dermatology. He was also a fellow of the American Medical Association.

Surviving are the widow, Mrs. Elizabeth Otto French, and several brothers and sisters residing in California.

Paul Oram Messner

Dr. Paul O. Messner of Miami Springs died in the Jackson Memorial Hospital, Miami, on Oct. 2, 1950. He was 48 years of age, and the cause of death was a cerebral hemorrhage. Interment took place in Cambridge Springs, Pa.

Born in Oil City, Pa., in 1902, Dr. Messner was graduated from the Washington Missionary College in Washington, D. C., and then taught school for several years before deciding to study medicine. He received his medical training at the College of Medical Evangelists, Los Angeles, interned at St. John's General Hospital in Pittsburgh, and then engaged in the private practice of medicine in Cambridge Springs, Pa. At the same time he served as medical director for the San Rosario Sanitarium.

During World War II, Dr. Messner was a flight surgeon in the United States Eighth Air Force and assisted the British in O. S. S. work. He returned to England in 1947 and again in 1948 for postgraduate study at the British Post Graduate School of Medicine and Institute of Cardiology.

In February 1949 he began the private practice of cardiology and internal medicine in Miami Springs, where he had resided since 1939 except when abroad. He first came there in that year as a member of the medical staff of Miami Battle Creek Sanitarium. Locally he was a member of the Masonic Lodge, the Miami Springs-Hialeah Lions Club and the Seventh Day Adventist Church.

Dr. Messner became a member of the Dade County Medical Association in 1942. He was also a member of the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Rose Messner, and two sons, Paul, Jr., and Charles of Miami Springs; and two sisters, Mrs. Dorothy Stroup and Mrs. Jean Watson of Port Arthur, Texas.

Joseph Ralph Vallotton

Dr. J. Ralph Vallotton of Daytona Beach died suddenly of acute coronary occlusion at his home on Oct. 5, 1950. He was 41 years of age. Interment took place in Valdosta, Ga., his birthplace.

Born in 1909, Dr. Vallotton was the second son of Mr. and Mrs. J. E. Vallotton. After completing his premedical education at Emory University in Atlanta, he received his medical training at the University of Georgia Medical School in Augusta, where he was graduated in 1934. A member of D. V. S. Honor Society, he was also a charter member and first president of Phi Chi fraternity. After interning at Jackson Memorial Hospital in Miami from 1934 to 1935, he took a postgraduate course in surgery in Vienna, Austria. He then served for a year as resident surgeon at the Florida State Prison Hospital in Raiford.

In 1936, Dr. Vallotton entered the practice of medicine in Daytona Beach, where he was a member of the surgical staff of the Halifax District Hospital for many years. He became a leader in civic affairs and was the first president of the Men's Garden Club of Daytona Beach. Later, he held office in the Southeastern Men's Garden Club as vice president and a member of the board of directors.

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**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

During World War II, this young physician served his country well in the medical corps of the United States Navy. After almost five years of service, he was discharged in 1945 with the rank of lieutenant commander.

Dr. Vallotton was a member of the Volusia County Medical Society, the Florida Medical Association, the American Medical Association, the Southern Medical Association, the Association of Industrial Surgeons, the Florida State Industrial Surgeons and the American Industrial Surgeons. In 1948 he was appointed a member of the Florida State Board of Medical Examiners.

Surviving are the widow, Mrs. Jeanette Maxwell Vallotton, a son, Maxwell, and a daughter, Susan.

Make Reservations Early

Hollywood Beach Hotel

Seventy-Seventh

Annual Convention

Hollywood,

April 22-25, 1951

Advertisement



From where I sit
by Joe Marsh

Sometimes Good Intentions Aren't Enough

That fire at the Hastings' place last night didn't do much damage, but Volunteer Chief Murphy was pretty angry about it. Spoke to some of us over dinner and a bottle of beer.

"Hastings' farm is a good mile from town," he said. "And by the time we'd dodged all the people on the highway who were going to watch, we hadn't a minute to waste.

"Then blamed if those sightseers hadn't parked cars right in Hastings' driveway and there was a mob around the house—just gawking. Joe, tell folks a fire's no sideshow. Ask 'em to think of the other fellow!"

From where I sit, sometimes even good intentions turn out to be unfair interference. Whether it's blocking the right-of-way of fire equipment, denying a man a chance to practice medicine where and when he chooses, or criticizing a person's right to enjoy a temperate glass of beer—the American Way is to give *everybody* his rightful "share of the road"!

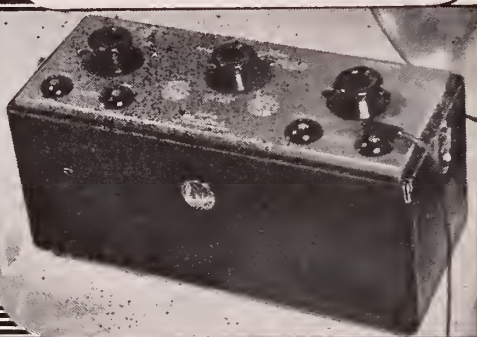
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What Every Doctor Should Know

The National Conference for State Presidents and Presidents-elect was held in Chicago on November 2 and 3, 1950. It was an Auxiliary sample piece. Pattern: America.

At this conference forty-four states were represented in addition to full attendance by the national officers and committee chairmen. The whole system of the organization was outlined. National officers working closely with the American Medical Association distribute the information to each State executive group, who in turn funnel it to the county officers where it is disseminated to the Auxiliary members on a local level. It resembles a hand-clasp, each extending friendship, cooperation and information on behalf of the doctors' interests. Those who, by becoming Auxiliary members, join hands across the nation with these women are prepared to resist adverse propaganda, dangerous legislation and other compulsory trends directed against the doctors because they have kept in touch and are educated to the threat.

The roll call of the states proved in its splendid representation that throughout our country the healthy dignity of medical allegiance is intact. We can continue to work in confidence that as the doctor and his wife become aware they will join us and help.

Dr. W. W. Bauer, Director of the Bureau of Health Education of the A.M.A., spoke on Health Education Media for a Woman's Auxiliary.

Dr. George Lynn spoke on civilian defense.

Dr. Ernest Howard, Assistant Secretary of the A.M.A. and liaison for the Auxiliary, spoke on current trends.

Miss Leone Baxter and Mr. Clem Whitaker spoke on Auxiliary activities and gave plans for the future.

After listening to these doctors and hearing the panel discussions made up from reports from every state treating of organization, public relations, educational programs and legislation we know we are of one fabric, the design of which is woven by the efforts of those who care about the medical profession. This design can be altered and botched or the purity of line can be carried throughout the nation depending on the stitches taken in time in your area, where ignorance can rent the whole cloth.

For example, the ideologies seeping into churches, schools and other organizations to which we belong can seem like innocuous solutions to current problems until it is too apparent that the color has changed. However bland a bleach may seem, though it whitens and appears to restore, it can eat away the fabric.

Because of these trends we need many more helpers to preserve and keep our house in order. American medicine is an institution we are obligated to keep intact; a refuge to which the poor, the sick and the helpless can repair.

Mrs. C. Robert DeArmas
President-elect

BOOKS RECEIVED

THE NATIONAL FORMULARY — NINTH EDITION. By the Committee on National Formulary. Price, \$8.00. Pp. 877. Easton, Pa.: Mack Publishing Company, 1950.

The Council of the American Pharmaceutical Association has announced publication of the Ninth Edition of the National Formulary. The book is one of the official compendiums for drugs under the provisions of Federal and State Food, Drug, and Cosmetic Laws. The Ninth Edition, representing the culmination of four years of planning and work by the members of the Committee on National Formulary, the staff of the American Pharmaceutical Association Laboratory, and hundreds of collaborators, became official on Nov. 1, 1950.

In the course of revision of N. F. VIII leading to the publication of N. F. IX, many changes in the content of the text were made. One hundred and sixty-two items official in N. F. VIII, most of which are no longer being used, were not admitted to N. F. IX, while 155 drugs with titles and standards have been added.

The National Formulary, now on a continuous revision basis, is a must for pharmacists and a valuable guide and official reference for physicians.

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GYNECOLOGY—Intensive Course, Two Weeks, starting February 19. Vaginal Approach to Pelvic Surgery, One Week, starting March 5.

OBSTETRICS—Intensive Course, Two Weeks, starting March 5.

MEDICINE—Intensive General Course, Two Weeks, starting April 23. Gastro-enterology, Two Weeks, starting May 14. Gastroscopy, Two Weeks, starting March 5. Electrocardiography & Heart Disease, Two Weeks, starting March 19.

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YOU AND YOUR HEART, A CLINIC FOR LAYMEN ON THE HEART AND CIRCULATION. By H. M. Marvin, M.D., and others. Price, \$3.00. Pp. 306. New York: Random House, 1950.

As mentioned in a commentary in The Journal last month, this book, prepared for the general reader, offers a concise, nontechnical explanation of the heart and circulatory system. Five eminent specialists, Drs. H. M. Marvin, Irving S. Wright, Irvine H. Page, T. Duckett Jones and David D. Rutstein, give authoritative guidance to all who are interested in this vital organ. There is a notable contribution to freedom from fear—the fear of heart disease—for they have collaborated to combat with facts the panic which affects many persons at the mention of such terms as coronary thrombosis, arteriosclerosis, high blood pressure, or rheumatic fever.

Here are the answers to questions which cover the problems of the healthy and the sick with regard to their hearts and blood vessels. Here is the truth, so far as medical science can supply it, about the various kinds of heart damage, what the chances are for getting them and what can be done about them. The book tells how much activity a man with heart disease can engage in as well as the role of diet, drugs, exercise, rest and emotions. It tells how heart disease develops. Above all, it tells how the heart and blood vessels work in sickness and in health, a reassuring account that will aid in putting an end to much needless mental suffering. Says Dr. Paul D. White in the foreword: "Never before has there been assembled under one cover for the layman such a wealth of accurate and useful cardiovascular information written in a clear and simple style."

FREUD: DICTIONARY OF PSYCHOANALYSIS. By Nandor Fodor and Frank Gaynor. Price, \$3.75. Pp. 208. New York, Philosophical Library, 1950.

Filling a need felt by the specialist and layman alike, this book presents for the first time a complete glossary of all the basic terms in psychoanalysis as defined and explained in the words of Dr. Sigmund Freud, founder of the school of psychoanalysis. The concise definitions, each taken word for word from the epochal writings of Dr. Freud, cover all the basic terms and concepts in this new science of the human mind. This volume is a convenient and useful reference work for the psychologist, psychiatrist and psychoanalyst and also affords a storehouse of information for the layman.

In the preface Theodor Reik states: "This book will help to correct the abundant misunderstandings and misconceptions among the intelligent people interested in psychoanalysis. Presenting Freud's ideas in quotations from his own work, the editors have given a kind of dictionary which can secure authentic information on the most important topics of psychoanalysis to the student who is in doubt. Such a dictionary is, of course, not to be used as a textbook of psychoanalysis. It can rather be used to correct many textbooks, now printed."

PRINCIPLES OF INTERNAL MEDICINE. By T. R. Harrison, M.D., Paul B. Beeson, M.D., William H. Resnik, M.D., George W. Thorn, M.D., and M. M. Wintrobe, M.D. Price, \$12.00. Pp. 1,590. Illus. 245. Philadelphia, The Blakiston Company, 1950.

The aim of this book is to present within the confines of a single volume a consideration of the disorders that comprise the province of internal medicine. An attempt has been made to integrate the pertinent content of the preclinical sciences with clinical medicine, and to approach the subject not only from the standpoint of disorders of structure, but also by way of abnormal physiology, chemistry, and disturbed psychology. Thus, this text for students and practitioners follows the modern trend in medical teaching.

Written by a distinguished staff of five editors and forty-eight contributing authors, each actively engaged in the field of medicine, it presents clearly and concisely basic mechanisms and concepts of disease in a way that enables the physician to recognize and understand the disorder in a manner that will be of immediate practical application in the care of the sick. It approaches the subject not only from the standpoint of manifestations and mechanisms of disease but goes on to discuss specific diseases so that knowledge is combined with greater understanding.

This new textbook of medicine, emphasizing the functional approach to specific disease treatment, is divided into seven parts. The first five cover the functional approach to the principles of internal medicine; the last two deal with specific infectious diseases and disorders of organ systems. The volume greatly benefits from the introductory account of the approach to the patient.



PRINCIPLES OF GENERAL PSYCHOPATHOLOGY, AN INTERPRETATION OF THE THEORETICAL FOUNDATIONS OF PSYCHOPATHOLOGICAL CONCEPTS. By Siegfried Fischer, M.D. Price, \$4.75. Pp. 327. New York, Philosophical Library, 1950.

This book is a survey of the most important psychopathologic phenomena and their theoretic bases. Part I deals with the fundamentals of psychopathologic concepts. Each chapter begins with a psychologic introduction for the understanding of the psychopathologic symptoms, all of which are described and defined. The diseases are mentioned in which they are found.

Part II deals with understandable and causal connections. Here, the author investigates what dynamic psychology and dynamic psychopathology really are and what their scientific foundations are. He takes a critical attitude to psychoanalysis, although with deep respect for the psychoanalytic school. An important new concept is added for the understanding of neuroses.

In Part III the syndromes or symptom-complexes of mental disturbances are described, and the diseases in which they are found are designated. Part IV deals with the foundations of personality, character and temperament and their deviations in pathologic cases. In addition to discussion of the normal, neurotic and psychopathic personalities, the relation between personality and psychosis is set forth. In the last chapter the author delineates the psychopathic from the neurotic personality.

Dr. Fischer is Clinical Instructor in Psychiatry at the University of California and was formerly Professor of Psychiatry and Neurology at the University of Breslau.

THE PHYSICIAN EXAMINES THE BIBLE. By C. Raimier Smith, B.S., M.D., D.N.B. Price, \$4.25. Pp. 394. New York, Philosophical Library, 1950.

Man stands at the gate of a new age. Shall he take the Bible with him across the portal? This unique book answers this question. The physician examines the Bible as to etiology, diagnosis and prognosis. Medical subjects in the Old and New Testaments and Apocrypha are presented and compared with present day practices.

The author, now a physician in general practice, was for several years a specialist in pathology and clinical laboratory science. He was also a teacher in medical, dental and nurses' training schools. His hobby was the study of the Bible. An elder emeritus in the Christian Church, he has taught young people's church school classes. His desire to answer the questions of youth in regard to the Bible and its relation to science, not in general terms but in detail, led to this book.

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| Dr. Marshall Brucer, Oak Ridge, Tenn.
Atomic Medicine | Dr. Harold A. Sofield, Chicago, Ill.
Orthopedic Surgery |
| Dr. Donald M. Pillsbury, Philadelphia, Pa.
Dermatology | Dr. Henry B. Orton, Newark, N. J.
Otolaryngology |
| Dr. Jerome W. Conn, Ann Arbor, Mich.
Endocrinology | Dr. Stanley P. Reimann, Philadelphia, Pa.
Pathology |
| Dr. H. Marvin Pollard, Ann Arbor, Mich.
Gastroenterology | Dr. Alfred V. Stoesser, Minneapolis, Minn.
Pediatrics |
| Dr. John L. McKelvey, Minneapolis, Minn.
Gynecology | Dr. Paul C. Hodges, Chicago, Ill.
Radiology |
| Dr. Arlie R. Barnes, Rochester, Minn.
Medicine | Dr. Nathan Womack, Iowa City, Ia.
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Medicine | Dr. Charles S. Welch, Boston, Mass.
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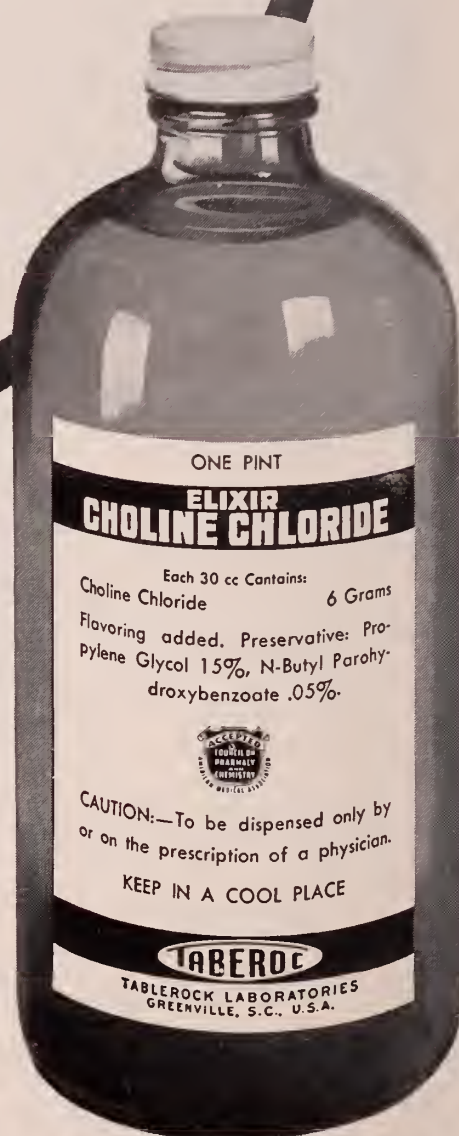
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Pensacola, 1951
B-Northeast	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	Orlando, 1951
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Bradenton-Sarasota, 1951
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	Vero Beach, 1951
Florida Specialty Societies			
Academy of General Practice	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	Hollywood, Apr. 22, '51
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	" "
Anesthesiologists, Soc. of	Ralph S. Sappenfield, Miami	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" "
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 2, '51
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	
Dental Society, State	D. Morrison, Sr., D.D.S., Gainesville	Larry Schulstad, D.D.S., Bradenton	Hollywood, Apr. 29-May 2, '51
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	
Hospital Service Corporation	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, June 24-26, '51
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
Public Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Houston, Texas, Dec 4-7, '51
Southern Medical Association	Hamilton W. McKay, Charlotte, N.C.	Mr. C. P. Loran, Birmingham	Dallas, Texas, Nov. 5-8, '51
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	St. Petersburg, April 4-6, '51
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg, Jan. 20-21, '51
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss.

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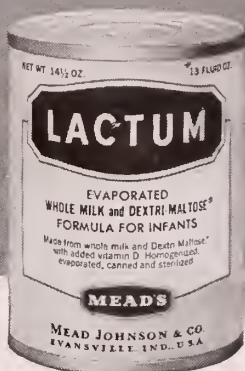
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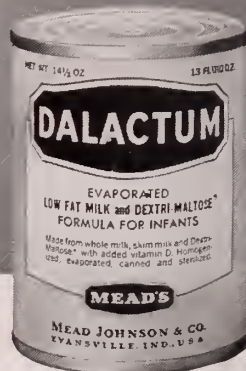
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

FEBRUARY, 1951

No. 8

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Modern Psychiatry

Lowell S. Selling



Antibiotics — Diseases of the Chest

Alexander Libow



February Anniversaries

An Editorial



March Journal will contain complete program for
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Volume XXXVII

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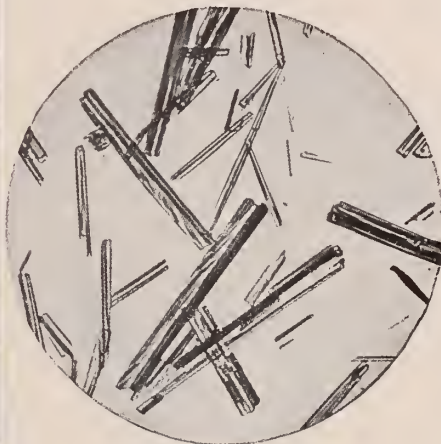
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(1) Mosenthal, H. O.: Management of Diabetes Mellitus: An Analysis of Present-Day Methods of Treatment, *Ann. Int. Med.*, 29:79 (July) 1948.

(2) McLester, J. S.: Nutrition and Diet in Health and Disease, 5th ed., Phil., W. B. Saunders Company, 1949, page 364.

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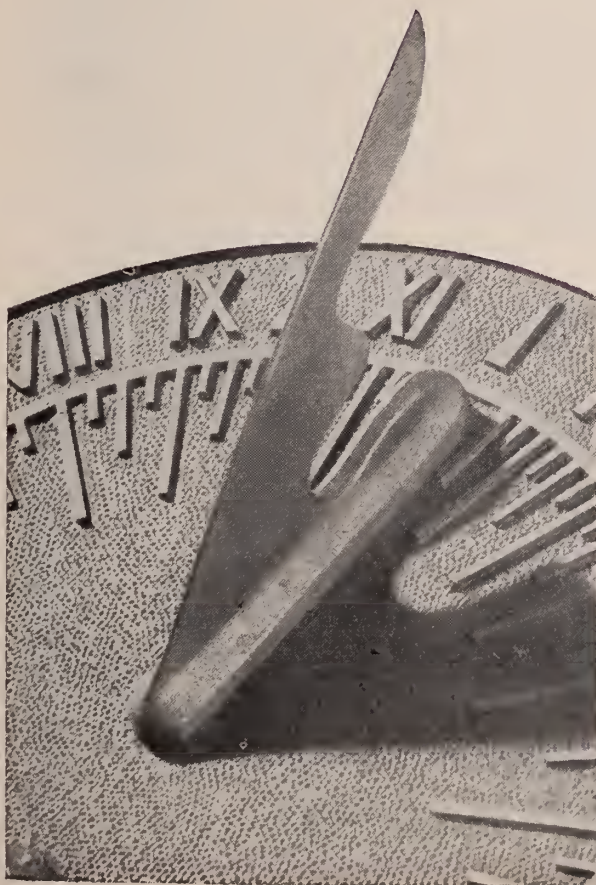
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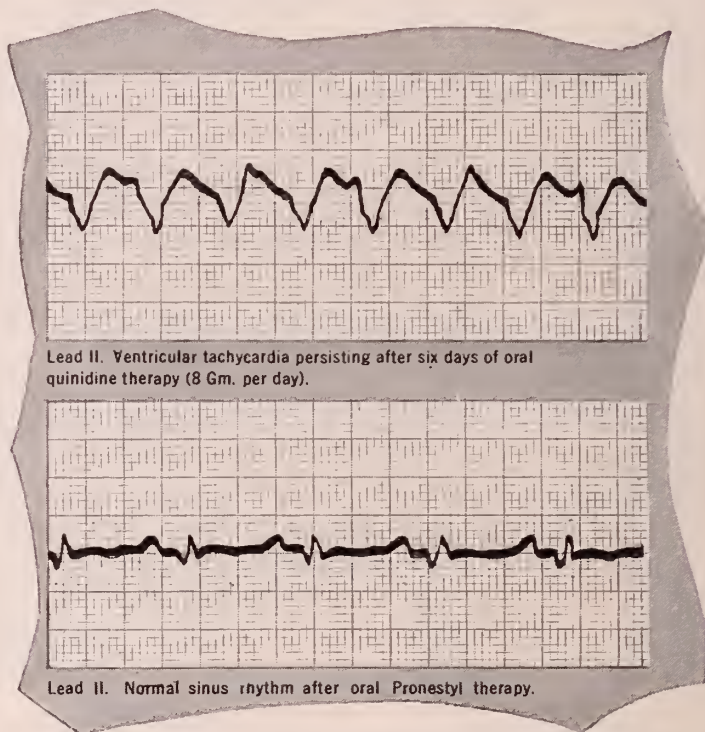
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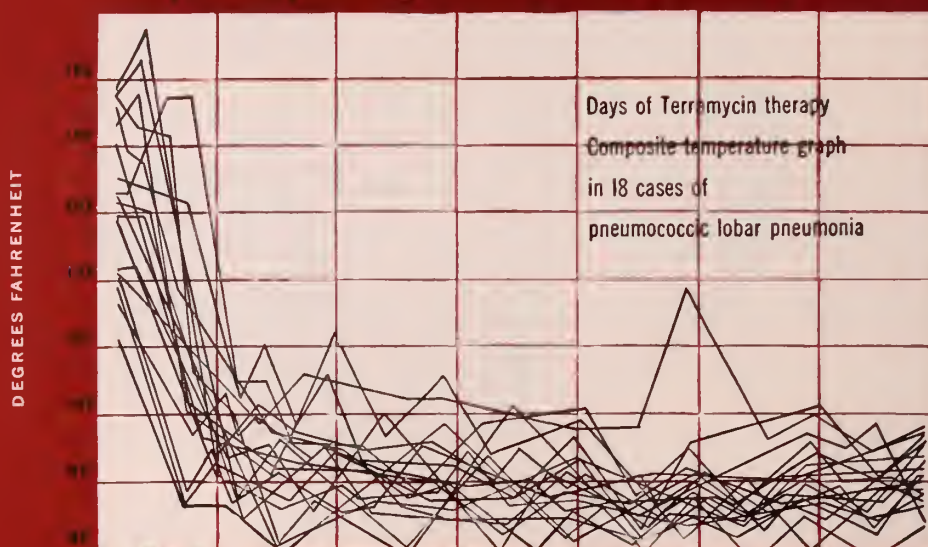
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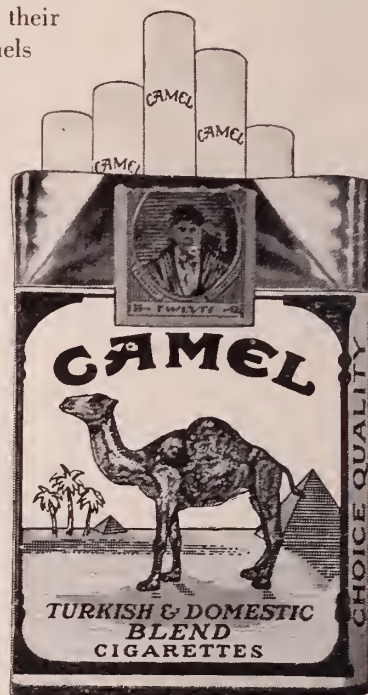
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SINCE 1876

Modern Psychiatry from the Practitioners' Standpoint

LOWELL S. SELLING, M.D.

ORLANDO

When one realizes that there are hundreds of journals being published on various aspects of medicine, it is obvious that even widely read periodicals such as *The Journal of the Florida Medical Association* or *The Journal of the American Medical Association* only skim the literature. One need not be surprised, then, that the knowledge which the general practitioner can gain of such a recondite specialty as psychiatry is limited. But psychiatry has a great deal to offer in providing treatment for seemingly strictly "physical" medical and even surgical cases, and physicians today need to know a great deal about psychiatry if they are to treat or even to refer to the appropriate specialist patients who will profit by strictly psychiatric treatment.

Since the turn of the century, much information has been added to our knowledge of the mind and how it works. The original brilliant researches of Sigmund Freud have been followed up by many of his disciples. They have modified them, amplified them, and perhaps in some cases overglorified them. But they have enabled the specialist in mental disease to concentrate on the interpretation of symptoms rather than on mere palliative medication. And in many ways they have, with regard to the abnormal psychology of the patient, represented the same trends that the physician, in dealing with physiologic problems, has followed in studying pathology, biochemistry and chemotherapy, to interpret the deeper meaning of physical symptoms.

The interpretation of psychologic symptoms requires too much amplification to be discussed here. Certainly we know that the anxiety and tension states which are so frequently brought to the physician, and which he tries to deal with by means of phenobarbital, thyroid extract and hormone extract, do not, as a general rule, if at all deep-seated, respond to medication.

More frequently than one would think, the patient becomes so discouraged with his lack of response to medication that he loses faith in physicians. He turns to faith healers, chiropractors and others of similar ilk, who largely, by giving the patient a great deal of attention and by sitting down and letting the patient talk about his problems, help to get him into the right mood so that his own basic mental stability overcomes the largest part of the abnormal symptom complex.

Certain general rules can be adduced from this knowledge. One is that if there are sufficient psychiatrists available, patients with obvious psychoneurotic or psychosomatic disorders, who do not respond quickly to the use of medication, should be properly referred for expert psychotherapy. It is interesting to note, in this connection, that the patient who is referred early in the course of his psychosomatic or psychoneurotic disorder and recovers, or is helped by a psychiatrist, forms a deeper attachment to the physician who originally referred him. If, on the other hand, the physician who refers the patient waits until he is pretty much discouraged, it is harder for the psychiatrist to treat the patient, and often the patient, when some physical disorder occurs later in his life, will seek out another physician. Of course, the attitude of the patient that (1) it is a disgrace to go to a psychiatrist and (2) it is extremely expensive to go to one depends on early referral. If his disorder is allowed to become chronic, he frequently has the feeling that he "must be crazy or they wouldn't be sending me to a psychiatrist." And, of course, the longer the condition exists and the more deep-seated it becomes, the more expensive it is for psychiatric treatment.

Does this, then, mean that in all cases of psychosomatic disorders the patient must be referred to a psychiatrist? By no means. As a matter of fact, there are innumerable cases in which there

will be response to careful and understanding psychiatric treatment by the family physician. I do not mean by this that the family physician must be able to carry out a complete course of psychoanalysis, nor that he should delve deeply into the sexual life of the patient, although the latter cannot be ignored.

In a recent report Wilbur¹ pointed out that a careful study of the environmental situation, as well as a careful study of the body of the patient, is, to begin with, good therapy. The patient knows that he is being studied; he knows that care and attention are being given him. And oftentimes, women who become neurotic in middle age are responding only to the fact that they are no longer getting the attention they got when they were younger. Even men who are ill have the subconscious desire to become more important than they feel they are. Frequently they belittle themselves so that the doctor will contradict them and build them up emotionally. Sometimes they are too discouraged for that type of build-up, but when they realize that everything is being done for them, it helps them. For this reason the patient needs plenty of time to talk to his physician. Much value from psychotherapy comes from just talking at random, letting some of the patient's complaints come out of his system. It has a strangely sedative effect, somewhat like giving a bland diet to an ulcer sufferer.

But only too often nowadays, when physicians are extremely busy, the patient gets a sense of being merely a product from a medical assembly line. There are no therapies that the physician can give to the psychologically unstrung that can compare in effect with the impression that the patient is his chief interest, that time is not limited, and that the physician is prepared to sit down and give him good advice.

On the other hand, when careful study shows that the patient is suffering from a disorder which is apparently not of physical origin, an easy way to make his condition chronic is to tell him that it is "imaginary." For that patient, the feeling of tension, anxiety, headache, or what he might have is just as real to him as if it were something physical. I have found that it is safe to tell a patient that his condition originates in his nervous system, and a simple explanation of how the nerve tracts work in coordination and balance when the patient is tremulous or unsteady, will give him the assurance that something can be done for him, which often sets him on the path to recovery.

Psychotherapy

In the early days of psychotherapy, when Freud's work was beginning to be known, many physicians decided that the problems of the maladjusted spinster were due merely to a lack of sexual intercourse and that in the case of married couples, when there was friction or neurotic disorder, the maladjustment was in the field of the simple sex act. Continuous and expanding study has shown that, although adjustments are extremely important in the causation of anxiety states, fear states, tension and fatigue states, the sexual maladjustment is in the field of patients' ideas of sex rather than in the act itself. Of course, it is true that there are persons, particularly women, who are apparently frigid and men who are impotent, who are dramatically serious, but they comprise only a small fraction of the sexually maladjusted. These exist because their parents gave them guilt feelings about sex or because they have feelings of shame or guilt about masturbation, or they have deep-seated memories about sexual wishes during their childhood periods of development, all of which lie outside the field of correction by sex education.

It is true that in many cases, particularly in young people, a valuable scientifically prepared manual on sex and a discussion of the sex act with the physician are of extreme importance, but in many instances the physician has a great deal to learn as to what constitutes the normal sex act or rhythm, for even physicians were startled by the findings in the Kinsey Report, which indicates how much more frequent masturbation and sexual "perversion" are in normal people than we had been led to believe.

Our ideas on the subject of medication for persons having tension states have changed rather drastically in the last ten years. When phenobarbital and its cousin, mebaral, came out, the feelings of relaxation which the patient gained lead many of us to believe that this was the answer to the psychoneurotic problem. It did not remove the cause, however, and those relatively few patients who recovered by the sagacious use of these drugs did so by enabling nature to clear up the problem.

The use of thyroid as a stimulant has, in my experience, given rise to much uncorrectible after-effect. Many patients have come to me after taking thyroid extract over long periods of time whose metabolism has been permanently changed. In some, hyperthyroidism has actually developed. None of them has been cleansed of any psycho-

neurotic taint. Of course, there must be some who have undoubtedly recovered who have not been observed by a psychiatrist because they did get well, but the number of patients who have had repercussions later in life because of long-continued use of thyroid is surprising. Whether this observation will prove true after a while in the case of benzedrine and similar stimulating drugs cannot be predicted, but certainly it is true that in many cases in which the patient is actually depressed and cannot sleep, the use of benzedrine aggravates these symptoms, although the patient may feel a little better during the day. In order to help the psychoneurotic patient, therefore, medication should, I believe, be used sparingly.

If the physician cannot employ psychoanalysis or hypnosis because of the need for the special preparation for these technics and the opportunity to use real psychotherapy does not seem to occur often enough in his practice for him to take training, he need not be discouraged. There are milder forms of psychotherapy which he can use: (1) Strong suggestion, particularly if it is based on scientific knowledge of the patient's condition, is helpful. (2) The doctor needs to take a bright, cheerful attitude and never let pessimism come into the discussion of the symptoms. (3) A common feature of the psychoneuroses, even when the patient is recovering, is the fact that he has good and bad days, and he should not be permitted to become discouraged when he feels bad, but should, rather, feel that he has access to the physician even if he is going to take a long time on the telephone. Psychiatrists often arrange for the payment of fees for long telephone conversations, and set aside special times so that the patient can get them and spend the necessary time on the telephone. This, of course, is not ideal psychotherapy, but may be necessary and may be useful, too, in the hands of the physician who wishes to do what he can for the psychoneurotic patient.

Depression

Psychiatry is learning a great deal more about the nature of depressions since the development of electroshock therapy. Many people, physicians as well as laymen, have the idea that electroshock therapy is useful for only those persons who are "insane." This is not true. In smaller doses, with more recently developed equipment, modern electroshock methods are painless, there is no electrical feeling connected with them, and in many instances they do not need to be given in the hos-

pital, although cases in which office treatment is suitable must be well selected and every precaution must be taken for the patient's safety.

With the increased knowledge of what is meant by depression, the physician is learning to have this type of treatment carried out in more and more cases, oftentimes with dramatic results. This group of cases is characterized primarily by difficulty in sleeping, feeling of depression, particularly in the morning, and without any reference to what has happened to the patient. Sometimes factors can be adduced to which the family will ascribe the cause, but as a general rule, these causes are not sufficiently severe to be a basic factor in the patient's illness. Rather, disturbance of the endocrine glands seem to have a greater part than psychologic causes, such as sudden poverty, sudden loss of a relative, and a number of emotional or financial problems coming upon the patient who is illy prepared for them. These appear to be exciting rather than the basic causes.

The basic causes are frequently noted in connection with the menopausal period, sometimes the immediate postpartum period (the latter having been named by someone the parapartum psychologic depression), and extremely frequently occur after some type of surgical intervention with the female genital organs.

A large proportion of patients who have had operations in which the uterus, the ovaries, or some substantial part of these organs has been removed, have long time depressions which do not respond to estrogenic substances. Oftentimes in these cases the condition improves with the administration of estrogens, only to lapse and to become persistent.

In the male, the causes of depression are somewhat different. Usually they are mild manifestations of manic-depressive psychosis. The menopausal depressions in the male are not as characteristic or as frequent as they are in the female.

Some of the symptoms occurring in the female, which are rather characteristic and which may be present only in a mild degree, are self-accusatory ideas. The patient feels she has not done as she should have for her family, that she has been nothing but a burden even though she may have been a good housewife and good mother up to the period of her depression. She may also have a desire to remove herself from this world, although this state is not frankly suicidal unless so severe that it constitutes a major psychotic depression. But the patient always has the idea that she would

be happier if she were not alive. She may describe her symptoms as feeling she does not want to do anything or she cannot make herself work. I have had several patients of this sort say they felt as though only part of the mind was working.

This whole group of patients responds well to various types of electroshock treatment. There are several different types of apparatus which the psychiatrist should have at his fingertips if he administers shock therapy. If there is more anxiety than depression, one type of equipment is used; if depression is the major symptom, another type is used. A decision as to which type is to be used would have to rest in the hands of the therapist. But it is necessary for the physician to recognize the fact that a depression of only a few months' standing is likely to respond to shock therapy with a minimum of discomfort, a minimum of pain, and a minimum of hospitalization. In fact, in some of these cases the patients are now being treated in the offices of psychiatrists, and the sooner they get into the hands of the psychiatric therapist, the quicker their recovery and their return to a healthy, normal, pleasant life. In resistant cases there sometimes follows one treatment a week or two treatments a month for a period of time after the first series is complete. The number of treatments to be given would have to be determined largely pragmatically. I prefer that the patient suffer a decided loss of memory for a few days before I discontinue the treatment. This means that, when other therapists will consider a series of from six to eight treatments adequate, it may take as many as ten or twelve in an average case of depression, particularly during the menopausal period, to obtain permanent results. We often hear the complaint that shock treatment is not a permanent treatment. It is doubtful if anything in medicine is permanent, but we do have complete recoveries which last for long periods of time. Many patients treated during the early days of shock therapy are still well and have had no relapse. Oftentimes the relapses which occur, do so because there is pressure upon the psychiatrist to discontinue the treatments, sometimes before he thinks that the patient is well able to stand on his own feet, and even when he believes that further treatment is really necessary to complete the series. Such a patient does not experience relapse because the treatment is unsatisfactory, but rather because there is difficulty in keeping the patient under treatment long

enough to make sure that there is adequate therapy.

The number of chronic or recurring cases of depression which fall into the hands of the general practitioner is much larger than one thinks, and they are more frequently mismanaged than is usually believed to be the case. This conclusion is indicated by the recent report of Stone and Burris.² If the patient knew of the conditions and circumstances surrounding shock treatment, in a majority of instances she would prefer two to four weeks of some discomfort and unpleasantness during treatment to months of suffering and unhappiness.

I must emphasize, however, that it is wiser for the physician referring a patient for possible shock treatment to leave the decision as to therapeutic procedure in the hands of the psychiatrist. Frequently there are circumstances surrounding a particular case which make psychotherapy the treatment of choice. Sometimes the mere bringing of a new pair of eyes to observe the symptoms of the patient will disclose that the condition is clearing up, while again anxieties and other psychoneuroses which appear to be accompanied by depression will not respond to shock treatment because they are not true depressions but fall into a simulating group of psychoneuroses that must be taken care of by psychotherapy.

Treatment of Psychosomatic Symptoms

py, where will he find his best tools for treatment in the case which is characterized by tension of the neck, migrating aches and pains, psychogenic paralysis, gastrointestinal symptoms like "butterflies in the stomach," or the palpitation of the heart?

Unless the matter be urgent or severe, or the physician knows at the onset that he will not be able to give the time and attention to the case, a brief period of psychotherapy, making use of the

If the psychiatrist or the physician is not to treat the psychoneurotic patient with shock therapy, the physician's own close relationship to his patient and following the procedures described in the first part of this paper, should be tried before the patient is referred to the psychiatrist. But when the condition is obviously one for long time therapy, is resistive to the physician's therapy for over a month and deserves a great deal of attention or is difficult to diagnose, it is probably one for the specialist.

While the patient is always afraid that he is

stigmatized by going to the psychiatrist, I have observed that most physicians can offer evasions, such as, "Of course he is a psychiatrist, but he is also a neurologist—a specialist in the conditions of the nerves." Or, "You know, nowadays psychiatrists treat many rather mild conditions such as yours."

It is well not to allow the patient to jockey the physician into predicting what course of treatment the psychiatrist will follow or how long the treatment will take. If the psychiatrist is going to use psychotherapy, he will probably use one of the following technics: (1) Psychoanalysis or one of its modifications means long and frequent sessions with the patient, in which he allows his mind to follow its natural train of thought until critical memories are brought into the open—a process known as catharsis, whereby the mental "toxins" are evacuated in much the same way that patients get physical relief from intestinal catharsis. (2) Hypnosis consists of using suggestion in order to build up the patient's self respect and courage so that he can use his own nervous powers to subdue his physical symptoms. Although any physician, or for that matter any layman, could learn the technic in half an hour, constant, almost daily, use of it and original training under supervision are necessary to get the best medical results from hypnosis and suggestions. Hypnosis cannot be as deep as it has to be in a stage presentation. The psychotherapist is not interested in producing antics to make the patient a dramatic subject, but rather is interested in convincing the patient against his will that he is going to get well. The psychiatrist cannot afford to fail because one failure of hypnosis or, for that matter, any form of

psychotherapy creates skepticism in the mind of the patient. The use of hypnosis in psychiatry is much more frequent than physicians realize, for it is a quick-acting tool, sometimes producing almost miraculous results, although, occasionally, these may only be temporary. Even if the result is temporary, it is encouraging and does not act like the temporary effects of drugs, which often-times leave the patient more discouraged than when he started his treatment. It is most useful when the patient can afford neither time nor money for a long series of treatments and, unfortunately, most patients are still hard to convince that a dollar spent on medical care is the most valuable dollar he can invest.

Summary

I have tried to cover briefly the most important phases of today's psychiatry, which differs greatly from the psychiatry of even fifteen years ago. I could only touch on high spots, of course, and I have had to deal with some superficial issues rather dogmatically. I am hoping that there are enough hints and suggestions in this paper to help the physician deal with the most difficult patients who come into his office, those suffering from psychoneuroses, depressions, and psychosomatic symptoms.

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Fatal Aplastic Anemia Associated with Mesantoin: Report of a Case with Autopsy

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Mesantoin was first introduced for the treatment of grand mal epilepsy in 1945 by Loscalzo¹ and Kozol.² It is closely related to diphenylhydantoin, both of which belong to the hydantoin group. The chemical formula of mesantoin is 3-methyl-5, 5-phenylethylhydantoin. The drug has been accepted with a great deal of enthusiasm because of its low toxicity. The commonest toxic manifestations have been drowsiness and minor skin irritations. Loscalzo¹ reported that in 4.5 to 14 per cent of his cases he observed skin reactions and in approximately 40 per cent he noted a moderate increase in the lymphocytes at the expense of the polymorphonuclear cells. It is the consensus of those who have utilized this drug to any extent that the patient should have the benefit of monthly physical examinations and hematologic studies and that one should view with suspicion any decrease in the hemoglobin and granulocytes.

A review of the literature on the use of mesantoin in grand mal epilepsy reveals that several cases of aplastic anemia and associated conditions have been reported. Harrison, Johnson and Ayer³ reported a fatal case of aplastic anemia in September 1946, but the patient had also been taking tridione. Bloom, Lynch and Brick⁴ reported a case of aplastic anemia with recovery in October 1948. Holland and Frank⁵ in December 1948 reported 2 cases of pancytopenia, in one of which the patient died. England and McEachern⁶ reported a fatal case in February 1949, and the most recent case in the literature, reported by Forster and Frankel⁷ (April 1949), also terminated fatally.

Report of Case

Mrs. L. W., a white woman aged 31, was first seen by the neuropsychiatrist on Oct. 2, 1948, at which time she was in the hospital following delivery of a full term infant. She gave a history of having had convulsive seizures since the onset of menses at the age of 14, but no seizures had occurred during the pregnancy. They usually occurred during menstrual periods, and she would sometimes have several attacks during the day. There was no family history of convulsive disorder and no history of serious in-

jury. She had three seizures during the first twenty-four hours following delivery. Neurologic examination gave negative results except that the patient was drowsy and confused.

The treatment prescribed consisted of 1½ grains of dilantin and ½ grain of phenobarbital three times a day following meals. She was discharged from the hospital on October 10. On November 1 she stated that she had had no further seizures, but that she was weak and tremulous. Weakness and trembling continued, and early in December she fell with the baby. She was examined by her family physician, and her blood count at that time was reported as normal. On December 13 she was advised to discontinue the dilantin and was given mesantoin 0.1 Gm. three times a day following meals. She was not seen by the neuropsychiatrist, but made the following reports to him on the telephone: On December 23 she was feeling much improved in every way and had had no seizures. On Jan. 5, 1949, she had a seizure. She stated that she had been menstruating for several days and the day before she had had a dental extraction. She was advised to increase the mesantoin and the phenobarbital to four times a day. On January 28 and March 2, she reported that she was getting along well.

The patient was seen by her dentist on September 14 for a routine survey and cleansing of her teeth. The dentist noticed that the slightest trauma to the gums would precipitate an oozing of blood that was difficult to control. She was referred to her family physician and after a delay of several days went to see him. At this time she had numerous petechial hemorrhages in the mouth, and there were two small, eroded dirty ulcers on the right side of the lower lip and the inner surface of the right cheek. The remainder of the physical examination gave essentially negative results. She was given 300,000 units of procaine penicillin and some sulfadiazine tablets to take orally. Her condition became progressively worse, with development of fever, weakness and great drowsiness. She was hospitalized on September 23. On admission her temperature was 102.6 F., pulse 100 and regular, respirations 20. There was pronounced pallor, and the gums and cheeks revealed numerous petechial hemorrhages. The ulcers described previously were still present. Examination of the heart and lungs gave negative results; the blood pressure was 112 systolic and 60 diastolic; the liver and spleen were not palpable. The patient was having a regular menstrual period at the time of admission.

Laboratory work on admission revealed: hemoglobin 4.5 Gm., red blood cells 1,300,000, white blood cells 1,500, anisocytosis and poikilocytosis, and a differential count of 90 per cent lymphocytes, 8 per cent segmented forms and 7 per cent stab forms. Urinalysis gave negative results. Bleeding time was four minutes and clotting time two minutes; there was no clot retraction in twenty-four and seventy-two hours. Roentgen examination of the chest gave negative results. Agglutinations and blood culture were negative. Platelets were 15,720 and reticulocytes 5.3 per cent.

Table 1 shows the reports on the blood work during treatment.

Table 1

Dates	Hemoglobin (Grams)	Red Blood Cells	White Blood Cells	Differential (Per Cent)
9-24-49	8.5	2,460,000	620	94 lymphs. 2 stabs. 4 segs.
9-26-49	12.0	3,560,000	350	100 lymphs.
9-27-49	13.0	4,028,000	950	99 lymphs. 1 seg.
9-28-49	14.0	4,570,000	950	100 lymphs.
9-29-49	15.5	4,700,000	1000	100 lymphs.
9-30-49	15.5	4,630,000	950	99 lymphs. 1 eosino.
10-1-49	14.5	4,500,000	350	100 lymphs.

Treatment

The patient was given daily transfusions (total of 9 pints), massive doses of penicillin, pentnucleotides, vitamins by mouth, and liver and folic acid parenterally. The epileptic attacks were controlled by phenobarbital in 1 grain doses four times a day. The medication had no apparent effect on the condition which became progressively worse. On September 30 she had two severe epileptic convulsions, and hematuria developed. On October 3 there were numerous moist rales in the chest, and the temperature was 106 F. by rectum. Aureomycin was administered intravenously, but she became progressively weaker. Hemorrhages occurred from the mouth and nose, and she expired.

The report of the postmortem examination, made nineteen hours after death, follows:

"The body is that of a well developed, well nourished, thirty year old white female appearing older than her stated age. The body measures 5 feet 4 inches in length and weighs 120 pounds. There are small hematomas in both ante-cubital fossae and the right hip. There is slight but definite jaundice of the skin and sclerae. There is evidence of stomatitis with formation of a few white patches on the buccal mucosa. Arterial embalming has been done.

"The pericardial cavity contains 100 cc. of brownish red bloody fluid. The epicardium contains numerous small petechiae, as does the myocardium. The heart is small and weighs 250 Gm. The left ventricular wall measures 1.5 cm. in thickness and the right 0.5 cm. The heart is otherwise not remarkable. The aorta contains a few small subintimal atheromatous plaques.

"The pleural cavities each contain 150 cc. of serosanguineous fluid. A few petechiae are found over the pleural surfaces. The right lung weighs 1,250 Gm. and the left 800 Gm. The right upper lobe, most of the right middle lobe, right lower lobe, and left lower lobe are markedly hemorrhagic and solid. They do not float in water. The bronchi are filled with dark red bloody fluid. The microscopic picture of these lobes is that of hemorrhage into all structures. The rest of the lung shows edema and distention of all vessels.

"The peritoneal cavity contains a small amount of serosanguineous fluid. There are hematomas in the retro-peritoneal areas of the pelvis and in the mesentery of the large bowel. The stomach contains 1,000 cc. of blood. Its wall is hemorrhagic and thin. The liver weighs 1,550 Gm. and is very soft. The liver cells are small and compressed. The Kupfer cells are prominent and heavily pigmented. The spleen weighs 290 Gm. The follicles are very small. The sinusoids are dilated. The kidneys together weigh 230 Gm. They exhibit only hematomas of the pelves and slight interstitial edema.

"The bone marrow is very pale and grossly scanty. Microscopic section shows marked decrease in hemopoietic tissue and a relative increase in the amount of adipose tissue. The differential count gives 65 per cent lymphocytes, 10 per cent plasma cells, 2 per cent myeloblasts, 1

per cent myelocytes, 8 per cent normoblasts, 1 per cent megaloblasts, and 19 per cent Q cells."

"Diagnosis: Aplastic anemia. Pulmonary hemorrhages. Gastric hemorrhages. Multiple hematomas and petechiae. Icterus levis."

Comment

This patient was receiving mesantoin and phenobarbital in therapeutic doses for nine months. Careful questioning failed to elicit the use of any other substances which might be implicated. Review of the literature failed to reveal any report of aplastic anemia associated with the use of phenobarbital.

Summary

A fatal case of aplastic anemia associated with mesantoin therapy is reported.

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A Review of Antibiotics in Treatment of Diseases of the Chest

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When Fleming discovered penicillin in 1928, an entirely new era in the treatment of infections was begun. Since then, numerous antibiotics have been developed. The most commonly used thus far have been penicillin, streptomycin, aureomycin and chloramphenicol. This paper will deal chiefly with these four, limiting their usage to diseases of the chest.

Penicillin

The first and still the most useful is penicillin. This antibiotic is produced by the growth of the common mold, *Penicillium notatum*. It is most useful in the respiratory diseases caused by the following organisms: (1) *Diplococcus pneumoniae*, (2) staphylococci with the exception of *Staphylococcus aureus*, (3) streptococci with the exception of *Streptococcus faecalis*, (4) *Actinomyces bovis* and (5) spirochetes. The first most important disease in which penicillin rendered invaluable therapeutic aid was pneumococcal pneumonia; it practically eradicated this disease for few cases of frank lobar pneumonia occur at the present time. Penicillin is also of great value and preferable in those pneumonias due to the staphylococcus and streptococcus.

It is indicated in the treatment of acute and chronic bronchitis and bronchiectasis when administered by aerosol inhalation. Here, it produces a reduction in both the amount and character of the sputum, decreasing it greatly and converting it from a purulent to a mucoid character. In acute abscess of the lung, which is usually due to a gram-positive organism, penicillin has frequently avoided the necessity of surgery when administered by a combination of aerosol and intramuscular route. In chronic pulmonary abscess, penicillin has been useful both preoperatively and postoperatively in preventing complications and promoting better healing. Surgeons have recently noted a considerable reduction in the number of pulmonary abscesses observed and attribute this reduction to the frequent use of penicillin in those diseases which

have abscess of the lung as a complication. Penicillin is also of great value in empyema. In acute cases, a combination of parenteral and pleural instillation of penicillin after aspiration has in many instances avoided the necessity of surgery. If after one week of this treatment sufficient improvement has not occurred, then surgical intervention is indicated, since further delay might result in a thickened pleura and nonexpanding lung. Recently, streptokinase has been combined with the intrapleural administration of penicillin. This new agent is fibrolytic in mode of action and liquefies the pleural exudate, allowing its removal more easily.

Administration of penicillin before and after surgery for intrathoracic tumors has diminished greatly the postoperative complications. Its use in surgery of the heart and great vessels has been debated, because of the possibility that the penicillin might cause an increased tendency towards intravascular clotting. In cases, however, of *Streptococcus viridans* subacute bacterial endocarditis (without patent ductus arteriosus) 90 per cent recovery has been reported by Troutman and Vincent, in a review of their own and other cases, with adequate doses of penicillin, sometimes as much as 20 million units a day. Prophylactic administration of penicillin has been discouraged because of the possibility of developing a penicillin resistance or allergy. Exceptions, however, have been made for prevention of rheumatic fever, before and after dental extractions in patients with organic heart disease, and in surgery about the mouth, throat or rectum.

The methods of administering penicillin may be enumerated briefly. The preferred avenue of administration is the intramuscular route for a repository type of penicillin. At present, procaine penicillin in sesame oil is most commonly used. It has been shown that satisfactory blood levels of penicillin with an aqueous suspension of 300,000 units per cubic centimeter persist from twelve to twenty-four hours. Oily suspension of the same dose prolongs the penicillin blood level thirty-six to forty-eight hours, and if aluminum monostearate

is added, detectable amounts in the blood stream are present from forty-eight to seventy-two hours. In severe cases such as blood stream infection, large doses are necessary. For example, in subacute bacterial endocarditis or bacteremia without cardiac lesions, from 1 to 5 million units daily may be necessary. In these cases sensitivity tests should be employed as a preliminary measure to determine the exact dosage necessary.

The aerosol inhalation method of administration is especially useful in the diseases of the bronchi, and in abscess of the lung, since it is often difficult for penicillin in the blood stream to penetrate the thickened walls of inflamed bronchi and encapsulated abscesses. Penicillin by mouth is the least desirable avenue of administration since much of it is destroyed by the gastric juices and at least five times the usual dosage is necessary. It should not be used in severe infections. Local application of penicillin should be avoided as much as possible since it may cause sensitization of the patient. Intrathecal administration should also be avoided, not only because of possible irritation, but also because adequate concentration can be found in the spinal fluid after other methods of administration.

The action of penicillin depends on its absorption into the cell structure of the bacteria as evidenced by experiments with radioactive penicillin. Studies show low levels are bacteriostatic and high levels are bacteriocidal. As increasing amounts are absorbed in the cell structure of the bacteria, the organism begins to swell, and its appearance becomes granular and cloudy until it finally disintegrates. High enough dosage, therefore, should be used to be most effective. Eagle and Musselman observed a bacteriostatic effect, which persisted a number of hours after removal of the penicillin (experimentally done by neutralization with penicillinase). This suggests that the therapeutic action persists for many hours after the drug has fallen to ineffective concentration. Bacteria do not grow for three to eight hours after neutralization of penicillin administered. Tempel and Dye, using 1 to 2 Gm. of streptomycin every third day, have reported clinical and roentgenologic results comparable to those obtained by the 1 to 2 Gm. daily dosage schedule, without significant toxic reactions to the drug and with delay of emergence of streptomycin resistant organisms.

Penicillin resistance is not as much of a problem as with streptomycin, but it is a factor which has

to be considered. It has been shown that the basis for the resistance is penicillinase, which inactivates penicillin. Those organisms sensitive to penicillin do not produce penicillinase, while those that produce penicillinase are not sensitive. Experimental evidence suggests that changes in bacteria from sensitivity to resistance in both penicillin and streptomycin originate as mutations, the antibiotic eliminating the sensitive bacteria, allowing resistant mutants to develop.

The toxic reactions to penicillin have been divided by Criepe into two groups, the allergic and the nonallergic. The types of allergic reaction, according to this author, consist of (1) a serum disease pattern similar to that produced after an introduction of heterologous serum, characterized by fever, arthralgia and dermatitis of urticarial or angioneurotic type. These usually appear in three to twelve days and are reversible, disappearing after a short time in most cases. It has been suggested by Waldo and Tyson that this reaction is due to the coupling of the penicillin haptene to albumen in vivo, constituting an antigen for production of antibodies specific to this haptene group. They found that penicillin alone did not produce antibodies, but an albumen penicillin mixture did. (2) The second type is the anaphylactic reaction, which is much less common. It usually appears after the second or third administration of penicillin. This is an intensified serum disease pattern occurring from a few minutes to a few hours after the administration of penicillin, and may be severe enough to bring on collapse or shock. (3) The third is the atopic, in which a person subject to hay fever or asthma may be spontaneously allergic, so that after administration of penicillin, there will immediately develop an attack of asthma or hay fever. (4) The fourth is the ID type, producing a delayed erythematous papulovesicular rash after administration of penicillin in patients who have been previously sensitized to various fungi as a result of trichophytosis or some similar dermatophyte disease. (5) The fifth is the contact type of eczematous dermatitis produced by epidermal sensitization after topical application or handling of penicillin.

The nonallergic reactions are divided into two types. (1) The Herxheimer type consists of a severe exacerbation of manifestations produced by the massive destruction of spirochetes in the local syphilitic lesion, and also sometimes in eczematoid dermatitis produced by the liberation of bacterial products at the point of lesion. (2) The second is the toxic type, for example, when penicillin is intro-

duced intrathecally with consequent irritation. Penicillin desensitization is not practical in most cases of penicillin allergy.

Streptomycin

The second important antibiotic, streptomycin, was first described by Waksman in 1944. It is derived from strains of *Actinomyces griseus*. Streptomycin is effective against many gram-negative organisms resistant to penicillin. It is of considerable value in those diseases caused by: (1) Friedlander's bacillus, (2) *Pasteurella tularensis*, (3) *Pasteurella pestis*, (4) *Hemophilus influenzae*, (5) *Escherichia coli*, (6) *Bacillus pyocyaneus*, (7) *Brucella* (with sulfadiazine), and (8) especially the tubercle bacillus, against which it has been chiefly employed.

In tuberculosis, it has been found to exert a favorable influence on fresh exudative lesions, on the ulcerative mucosal lesions of laryngeal and intestinal tuberculosis, in primary tuberculosis (both pulmonary and glandular), and in posthemoptotic spreads. Autopsies in streptomycin-treated cases show a decided decrease in the amount of perifocal reaction about areas of caseation, a great decrease in intestinal and laryngeal complications and an increase in the amount of productive reaction at the periphery of caseous and pneumonic areas.

The mode of action of streptomycin in promoting healing is unknown. Healing is probably due to its bacteriostatic action on the tubercle bacillus, rather than its influence on the host. The inhibition of the bacteria probably affords the opportunity for the tissue reactions to proceed to fibrosis. For example, in chronic cases in which streptomycin therapy is employed, tubercles contain an unusual number of large giant cells with fibrosis. Such healing is not commonly observed in untreated cases. Evidences of benefit by streptomycin in the properly indicated types of tuberculosis are: (1) a drop in temperature, (2) a decrease in the amount of sputum, (3) sputum conversion, (4) a decrease in the sedimentation rate, and (5) a feeling of increased strength and well-being. Its chief limiting factors are: (1) the inability to close cavities, (2) the toxicity, and (3) the development of resistance to it by the tubercle bacillus.

Cavity closures have been reported with streptomycin therapy, but they are often more apparent than real. The cavities have been merely lost to view on the roentgenogram and soon reappear. Many have reported the thinning of cavity walls with streptomycin therapy. This is merely a reso-

lution of the perifocal reaction around the cavity wall. The perifocal reaction ordinarily stands out on the roentgenograms. With its resolution the well defined shadow disappears, and subsequently it is often difficult to delineate the cavity, although this cavity has not actually disappeared. Although unable to close cavities, streptomycin is nevertheless a valuable aid in those cases in which there is a contralateral spread. Here it allows temporary suppression of the contralateral disease permitting the collapse of the cavity side by other means. Streptomycin may be of some value in the treatment of pleural effusions by possibly preventing the pulmonary lesions, which so often follow. Streptomycin is also of value in the treatment of tuberculous empyema, with bronchopleural fistula. Surgery has been prevented in a percentage of those cases in which (1) the bronchopleural fistula was small, (2) there was an absence of secondary organisms, and (3) there was an absence of a thick fibrin cortex over the lung. Otherwise, surgery is the recommended method of treatment.

A preliminary course of streptomycin is recommended in surgical procedures such as pulmonary resections, in closures of cavernostomies, and especially when endobronchial tuberculosis exists. The mortality rate in pulmonary resections has been lowered to 1 per cent, from an original 15 per cent, by the judicious preoperative and postoperative use of streptomycin. Also, in pericardectomy, when tuberculosis is suspected as the cause of constrictive pericarditis, administration of streptomycin allows much earlier surgery.

The preferred method of administration is by intramuscular route. It may be combined with aerosol inhalation for tracheobronchial tuberculosis. Streptomycin is not absorbed by the intestinal tract, and its oral administration is not ordinarily recommended. Such usage, however, has been suggested as a preoperative procedure in surgery of the intestinal tract as a prophylactic measure, possibly by the beneficial action on the intestinal flora locally.

The most troublesome toxic reaction to streptomycin has been its effect on the eighth nerve, with damage to the vestibular component as evidenced by vertigo and occasional deafness, sometimes to an irreversible degree. A decrease in the dosage from 2 Gm. to 1 Gm. daily has diminished this complication considerably. Also, replacement with dihydrostreptomycin has decreased the possibility of vestibular complications. Other toxic reactions to streptomycin are various types of der-

matitis, the commonest of which are maculopapular and desquamative lesions. In a small percentage of cases, drug fever, eosinophilia, renal irritation, nausea and vomiting have been reported.

Resistance to streptomycin by the tubercle bacillus can develop with an amazing rapidity, and to a greater degree than with any of the other antibiotics. The favorable action of streptomycin is limited to the period of sensitivity of the tubercle bacillus. It has been shown that tubercle bacilli, resistant *in vitro*, are also resistant in the body, thus enabling the physician to decide in advance whether streptomycin therapy would be of value. In those cases in which improvement continues, undoubtedly the patient's natural resistance is allowed to become dominant. If, however, drug resistance develops prior to this event, then the patient returns to his original status. Strains of streptomycin-resistant bacilli emerge at a fairly regular rate, which appears to be independent of the daily dosage, but definitely related to the duration of therapy.

The duration of therapy varies. In 75 per cent or more of the cases with cavitation or caseous pneumonia streptomycin resistance will develop after one hundred and twenty days of treatment. Decreasing the interval to forty-two days will diminish the percentage to approximately 35. Other suggested methods of administration have been 1 Gm. every third day, or 1/3 of a gram daily in the hope of delaying development of resistance. The combined use of para-aminosalicylic acid (PAS) and streptomycin materially reduces the rate of resistance development, and also has a synergistic effect upon the tubercle bacillus. Dosage of PAS should be between 10 and 15 Gm. daily and dosage of streptomycin 1/2 to 1 Gm. daily. The toxic effect of PAS is mostly gastrointestinal, consisting of nausea and vomiting, which appear early and may subside. If not, the dosage may be diminished temporarily, discontinued temporarily, or administered in enteric-coated tablets, or granules, or in capsule form. Recently, the sodium salt has been made available commercially and is somewhat less irritating. PAS itself is bacteriostatic, not bacteriocidal. It exerts its effect on streptomycin-resistant strains equally as well as on streptomycin-sensitive strains, and thus far little has appeared in the literature about the development of resistance to PAS. It should not entirely replace streptomycin in streptomycin-sensitive cases, since it is not as potent as streptomycin. In streptomycin-resistant cases, it is of considerable value. Prob-

ably, the combination of streptomycin and PAS is the method of choice in all but streptomycin-resistant cases, in which PAS alone should be used.

Simultaneous administration of streptomycin and promizole in miliary and meningeal tuberculosis has been reported by Lincoln and Kirmse to be of considerable value. They reported a good survival rate in these conditions, 11 out of 13 in the miliary type, and 16 out of 21 in the meningeal type. Promizole is, however, somewhat toxic, and care must be taken in its use. The combination of streptomycin and PAS has been preferred by others in the treatment of miliary and meningeal tuberculosis.

In Europe, one of the thiosemicarbazone series called Conteben (Tibione, in this country) has been developed for use in pulmonary tuberculosis, and has been tried in combination with streptomycin. The action of this preparation appears similar to that of PAS, with a toxicity similar to the arsenicals. At present, PAS is preferable in combination with streptomycin.

Aureomycin

Aureomycin was first grown from the mold of *Streptomyces aureofaciens* by Duggan in 1948. It inhibits growth of both gram-negative and gram-positive bacteria and is active also against rickettsial and virus infections. It is of special value in: (1) atypical virus pneumonia, (2) the virus disease of ornithosis and psittacosis, (3) rickettsial diseases such as Rocky Mountain spotted fever and Q fever, (4) the bacterial pneumonias refractory to penicillin, such as those due to *Staphylococcus aureus* and *Streptococcus faecalis*, (5) brucellosis, in which it has been suggested as superior to the combination of streptomycin and sulfadiazine, (6) tularemia, (7) those spirochetal infections in which penicillin cannot be used, and (8) herpes zoster, in which it has diminished the duration and severity of symptoms. It is of debatable value in infectious mononucleosis, but a favorable chemotherapeutic effect on influenzal meningitis has recently been reported.

The oral method of administering aureomycin is the most convenient, and is preferred. The recommended dosage is 500 mg. every six hours until 30 to 50 mg. per kilogram of body weight per day has been given. For children or adults who cannot swallow capsules, the drug may be added to chocolate powder and given in milk or water. If necessary, aureomycin may be given intravenously, 30 to 50 mg. per kilogram per day, divided into

three doses and mixed with a special leucine diluent. When using aureomycin intravenously, however, the patient must be watched carefully since phlebitis may occur with this method.

As for mode of action, this antibiotic not only circulates in the extracellular elements of the tissues, but also has the ability to penetrate the endothelial cells, and to diffuse into the intracellular water of the tissues. This enables it to be effective against rickettsial and virus infections.

The toxic effects of aureomycin consist in nausea and vomiting in a considerable number of cases. They are probably not due to the antibiotic itself, but to some other factor present in the preparation of the mold. It is interesting to note that lately the preparation has had greater purity with a noticeable decrease in toxic symptoms. Simultaneous administration of aluminum hydroxide, milk or cottage cheese with the aureomycin has been found to diminish the occurrence of nausea and vomiting. Diarrhea occurs occasionally, and is probably a result of the disturbance of the bacterial flora of the colon produced by the aureomycin.

Chloromycetin or Chloramphenicol

This antibiotic was isolated by Ehrlich and Burkholder from the mold *Streptomyces venezuelae* in 1947, and at the present time can also be prepared synthetically. It is of value in the following infections: (1) rickettsial diseases, especially typhus fever, (2) the virus disease of ornithosis and psittacosis, (3) *Salmonella* infections, in which it may be superior to aureomycin, (4) atypical pneumonia, (5) *Esch. coli* infection, and (6) brucellosis. It has similar therapeutic effectiveness, but is probably preferable to aureomycin in typhoid fever, typhus fever, and the *Salmonella* group of infections. Aureomycin is probably preferable in atypical pneumonia, Rocky Mountain spotted fever, Q fever, ornithosis, psittacosis, and tularemic pneumonia. Both aureomycin and chloromycetin are equally effective in brucellosis.

A recent report of a severe epidemic of pertussis in Bolivia treated with chloramphenicol proved it to be of great value in this condition. The fever disappeared the second day of treatment, and a definite decrease in the number of paroxysms could be noted on the third day. After the sixth day, a slight cough alone remained in a few patients. A spot check by cough plate after one week revealed all cases free of infections.

Chloramphenicol is given by mouth in doses of 1 Gm. every six hours until the temperature drops

to normal, and then 1/2 Gm. every six hours for two days following. Toxic reactions are rare. There are no reports of any that were serious. Nausea, vomiting and mild skin eruption occur, but to much less degree and not as frequently as with aureomycin. Occasionally, loose stools also occur as a mild complication. The mode of action of chloramphenicol is bacteriostatic. Like aureomycin, it penetrates to a cellular membrane of body tissues, and therefore can be effective against rickettsial and virus infections.

Newer Antibiotics

Neomycin is derived from the molds of *Streptomyces fradiae*. Introduced by Waksman as superior to streptomycin, it has thus far been found too toxic to use clinically.

Polymyxin is derived from a soil organism, *Bacillus polymyxa*. There are several strains which have been confused with each other. The least toxic and most promising is polymyxin D. It is one of the most effective agents against gram-negative bacilli in vitro.

Streptothricin is derived from strains of *Streptomyces lavendulae*, and is valuable against fungi, but toxic when administered internally.

Tyrothricin is effective against gram-positive organisms, but can only be used topically since it causes a severe hemolytic anemia with internal administration.

Bacitracin is derived from strains of *Bacillus subtilis*. It is especially effective against gram-positive organisms topically, but because of toxicity to the kidneys, its internal use is limited.

Lastly, terramycin, produced by the growth of mold *Streptomyces rimosus*, has been introduced. Its sphere of usage appears similar to that of aureomycin with occasional gastrointestinal disturbances.

Summary

Treatment of diseases of the chest with penicillin, streptomycin, aureomycin, chloramphenicol (chloromycetin) and other newer antibiotics is discussed.

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The Causes of Embolism

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If one scans the English medical journals for the past eighteen months, he will find that well over 100 papers have been written on thromboembolic disease, and there are just as many in the foreign journals. It is evident at the outset, therefore, that the fundamental mechanisms and pathologic physiology are not yet fully understood.

In the great majority of cases, pulmonary embolism is caused by detached venous thrombi. Less common, but still well known, are emboli of air, oil and fat, and the rarer emboli of tumor tissue, bullets, amniotic fluid and meconium, paradoxical emboli, and foreign injected material such as penicillin-oil-beeswax.

Of the rare types, perhaps fat emboli have had less emphasis than they warrant. All are familiar with the fact that fat embolism occurs fairly often after fracture of the lower extremity, but it is doubtful if many physicians know that it also occurs following abdominal surgery. Robinson¹ recently reported 2 cases with which he had come

in contact in his relatively short surgical experience. He stated that fat embolism following abdominal surgery is often misdiagnosed or overlooked because it is difficult to substantiate conclusively and because it is rarely considered.

The present day concept of this condition is that liquefied fat enters an open vein because of the negative pressure, but there is as yet no agreement as to whether the symptoms are due to the mechanical blocking or to the toxicity of the fatty acid. The symptoms, which start in from six to forty-eight or seventy-two hours postoperatively, consist of moderate cyanosis and dyspnea followed by a hyperpyrexia which may go as high as 107 F. The pulse is weak and rapid, and the blood pressure drops to alarming levels. There is restlessness, irritability, and finally delirium, coma and death. The diagnosis is made by finding fat in the urine, and it must be remembered that these fat droplets float and are therefore in the last few cubic centimeters of urine to leave the bladder. A differential diagnosis must be made between massive

¹Read before the surgical group Graduate School of Medicine, University of Pennsylvania, Philadelphia, March 3, 1950.

atalectasis, cerebrovascular accident and fat embolus. If the condition is fatal, the patient will usually die within the first ninety-six hours. Treatment is merely supportive and consists mainly of forcing fluids to increase the urinary output, since this is the mechanism of fat excretion from the blood stream.

Air emboli are not uncommon and should be kept in mind in a variety of relatively benign-appearing procedures. A number of cases have been reported associated with drawing blood for transfusion,² following spontaneous pneumothorax, during antral irrigation and during vaginal insufflation. It should also be remembered that the accidental surgical opening of any large vein containing a negative pressure may cause a fatal air embolus.

Embolism from amniotic fluid and meconium is fairly common because of the large open vessels and sinusoids following parturition, although only 16 cases have been reported in the literature so far.³ This complication has been recognized only in the last few years, but it is of such importance that it has already been described in authoritative obstetric textbooks.

From the figures of the Chicago Lying-In Hospital over a period of the last nine-years, Steiner and Lushbaugh³ have estimated the incidence of fatal cases as being 1 in 8,000 deliveries. They found that pulmonary embolism by amniotic fluid was the commonest cause of death during labor and the first nine hours thereafter. In these cases, the cause of death is not obvious grossly at autopsy, and it is only on microscopic sections of the lungs that emboli consisting of meconium particles are found. As the condition becomes more widely recognized, the incidence may well prove to be much higher than is at present supposed.

Bullet or shell fragment emboli are extremely rare and only 9 cases are reported in the literature.⁴ The bullet either lodges directly in the vessel or erodes into it, and the propagation depends on gravity, the position of the patient and the rate of blood flow.

Paradoxical emboli are by definition emboli that arise from a vein but lodge in a systemic artery instead of the pulmonary artery. To accomplish this, the embolus must pass through a septal defect in the heart, which is usually a patent foramen ovale. This type of embolus is also rare, Young, Derbyshire and Cramer⁵ having recently reviewed the literature and found only 41 cases reported.

Fatal tumor emboli are not too rare, however,

and a number of cases are reported in the literature.⁶ These occur both spontaneously and when disturbed surgically.

The incidence of pulmonary embolus following venous sclerosing therapy is almost nil, Smith and Johnson⁷ of the Mayo Clinic reporting only 17 cases with 1 fatality in a series of 11,700 cases treated in the period from 1927 to 1947. It should be remembered, however, that any injectable material such as venous sclerosing solution and penicillin-oil-wax may cause an unexpected and preventable death from pulmonary embolus.

In the great majority of cases, pulmonary embolism is caused by detached venous thrombi, but the exact cause of the formation of the thrombi is still a mystery. Many mechanisms for intravascular clotting have been postulated in the past, but at present only a few definite facts relating to the mechanism are known.

General Factors

The generalized factors which can cause intravascular coagulation have been pretty well agreed upon as (1) damage to the vascular endothelium, (2) stasis of blood, and (3) a hypercoagulable state of the blood. Damage to the vascular endothelium may occur by direct trauma, inflammation, or ischemia of the vessel wall. Here the plasma thromboplastin becomes active, tissue thromboplastin in the wall of the vein seeps through and initiates clotting, and because of the small amount of fibrin formed, the platelets stick there and accelerate the clot formation. Two types of clot are recognized, the white clot, which is the result of vascular endothelial damage, and the red clot, which accounts for the great majority of emboli. The white, or fibrin, clot is firmly attached to the wall of the vessel and becomes endothelialized in about five or six days. The red clot is loosely attached to the wall of the vessel and is propagating in nature, extending for great distances as a floating clot. This type of clot is not easily endothelialized and causes emboli because it is easily broken off by the more rapid blood flow when it reaches a larger vein or from increased venous pressure produced by the Valsalva maneuver, such as occurs in coughing.

It has been established by Hunter, Sneed, Robertson and Snyder⁸ and by others that known damage to the vascular endothelium, such as occurs with thrombophlebitis, accounts for less than 10 per cent of the fatal pulmonary emboli; so one must look for other more important causes.

The second general factor, stasis of blood, has

long been associated with the production of phlebothrombosis and subsequent embolism. Factors which favor stasis⁹⁻¹³ are slowing of blood flow, periods of hypotension, vasoconstriction, polycythemia, fluid or plasma loss, decreased skeletal muscle tone, depression of respiration, localized pressure points, varicosities, and anything causing sludging of red blood cells.

Postoperative bed rest and medical bed rest of long duration certainly decrease skeletal muscle tone, slow the blood flow and create localized pressure points that generally produce stasis of the blood and favor thrombus formation. These conditions may also produce fluid and plasma loss and depression of respiration, and generally lead to sludging of red blood cells.

It has been well established that the site of bland thrombus formation productive of the majority of pulmonary emboli is in the deep veins of the calf and of the foot. Hunter, Krygier, Kennedy and Sneed¹⁴ found thrombosis of the lower extremities in more than 50 per cent of persons dying of any cause in the latter half of life. By leg exercise they were able to reduce this figure to just under 20 per cent.

At present probably the greatest single factor known favoring thrombus formation is the sudden confinement to bed of a previously ambulatory older patient without the benefit of active exercise. Although this is an important factor, stasis is not the true cause of thrombus formation since Miller and Rogers¹⁵ showed as far back as 1929 that a stationary column of blood in a vein or artery after two carefully applied aseptic ligatures may remain fluid for weeks in a living human.

Clinical factors increasing thromboembolism are heart disease, major operations, severe injuries, obesity, cold weather, other vasospastic influences, and debility.

The third general factor, a hypercoagulable state of the blood, has been postulated by many different investigators. They have ascribed this to drugs, excessive smoking, the surgical liberation of tissue factors and many other causes. Various investigators have shown an increase in the prothrombin, a decreased coagulation time, an increase in platelets, or more adhesiveness to platelets, but these are difficult to measure, and it has still not been definitely proved that any of them exist as a generalized factor in thromboembolic disease. This lack is attested by the fact that there is as yet no test which can predict the formation of thromboemboli.

Perhaps the most well known fact of all concerning the occurrence of thromboembolism is that its incidence is much greater in persons over 40 years of age. It is known that thrombosis occurs in over 50 per cent of the middle-aged or older patients forced to bed, but there is only the inadequate fact of stasis to point to as the etiologic factor. It has already been shown that this alone is not enough to cause intravascular clotting.

Another less well known fact is that pulmonary embolism is not purely a surgical complication, as one would be led to believe from the literature on the theory that surgical trauma liberates factors causing a hypercoagulable state in the blood. On the contrary, Carlotti, Hardy, Linton and White¹⁶ have shown that pulmonary embolism is actually more common in medical than surgical patients. In their medical patients, 65 per cent had cardiac disease, especially the rheumatic, hypertensive and coronary forms. Congestive failure was frequent as a background, and auricular fibrillation was present in nearly one third of the patients. Of these patients, 83.3 per cent were over 40 years of age, and over half of them were from 50 to 70 years of age.

Ochsner^{17a,b} has repeatedly stated that the precipitating cause of thromboembolic phenomena is blood stasis, but it is hard to explain the fact that emboli are extremely rare in paraplegic and tetraplegic patients and in patients with tuberculosis. Cook and Lyons¹⁸ showed that in a series of cases of patients with paralyzed legs for a total period of 115 man years, there were no instances of pulmonary embolism despite the stasis and the fact that these patients had been subjected to 175 surgical procedures. The blood of these patients contained sufficient quantities of all the factors to cause normal clotting. There were blood stasis, surgical trauma, repeated infections, general debilitation, and in tetraplegic patients even the loss of primary muscles of respiration, all of which favor thromboembolism. The average age of the patients, 26.1 years, was the only factor unfavorable to the development of emboli. Fox, Robitzek, Bernstein and Bobb¹⁹ reported only 30 cases of pulmonary infarction in twelve years at a tuberculosis hospital covering some 24,263 admissions. Twelve of the infarctions were fatal and were among the 22 found in 2,182 necropsies done there. Their conclusion was that bed rest was not a factor in the production of embolism. Here again, the majority of the cases were in the younger age group. In this connection, Cook and Lyons¹⁸ pos-

tulated that the influence of advancing age on thromboembolism may be the concomitant decrease in the human source of heparin, the mast cells.

de Takats^{20a} has shown by a simple clotting mechanism test that people react differently to heparin. There are hyporeactors, normoreactors and hyperreactors. He found that in the early postoperative period, that is the first two or three days, patients were somewhat heparin-resistant. In his latest monograph^{20b} he stated that a decreased response to heparin is found also with age, acute thrombosis, dehydration, hemoconcentration, polycythemia, hyperlipemia, carcinomatosis, and when digitalis and epinephrine are used.

Although many authors continue to write on the thromboembolic problem, most of the papers and investigation are concerned with treatment of the disease and only a few with determining the etiology. Even the incidence of pulmonary embolism, as reported from studies on consecutive necropsy material, varies from 2.07 per cent to 6.8 per cent.^{21, 17b} An attempt to correlate and explain the difference in occurrence seems almost hopeless when Allen²² reports 26 fatal emboli in a series of 458 surgical cases and Zimmerman, Miller and Marshall²² find only 43 fatal emboli in 152, 371 cases of major operations over a seventeen year period, as proved by consecutive autopsy material.

Admittedly, this is a difficult problem because of the inability to diagnose these cases clinically. Yet it would seem that studies of necropsy material under an accepted and standardized technic should at least establish a comparable incidence of the disease.

Summary

The great majority of emboli are caused by detached venous thrombi arising from the deep veins of the calf of the legs and deep veins of the feet.

Emboli are as common medically as surgically, or more so.

The two main etiologic factors known today are age and blood stasis.

Proof of a hypercoagulable state of the blood causing thromboembolism is still lacking. There is no blood test which will determine a tendency toward the production of embolism.

The reported incidence of embolism still shows a wide variation.

Of the rarer types, air emboli, fat emboli, and amniotic fluid and meconium emboli are being diagnosed with more frequency.

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ABSTRACTS OF MEDICAL ARTICLES

INCIDENCE AND SIGNIFICANCE OF THROMBOEMBOLISM IN PULMONARY TUBERCULOSIS. By Russell S. Jones, Thomas C. Black, and Harold A. Sparr. *Am. Rev. Tuberc.* 61:826-834 (June) 1950.

It is the purpose of this paper to indicate greater frequency of pulmonary thrombotic emboli in pulmonary tuberculosis than is generally believed, the importance of small emboli lodging in the arteries of the good pulmonary tissue in cases of pronounced pulmonary tuberculosis, and the rarity of infarction associated with these emboli. Eleven examples of pulmonary thromboembolization were found on careful postmortem examination of 60 consecutive tuberculous male patients with an incidence of 18.33 per cent. The emboli in these patients lodged in the arteries supplying the good pulmonary tissues and away from the areas of the main tuberculous involvement. In only one instance were the pulmonary emboli associated with infarction.

The high incidence of pulmonary thromboembolism in this series is attributed to the careful dissection of the lung rather than a review of protocols, the extensive pulmonary tuberculosis with cor pulmonale in 5 of the 11 cases, inadequate fluid intake in seriously ill patients, and age over 40 years in 9 of the 11 cases.

Other factors in venous thrombosis are outlined and the possible relationship of reduced blood volume in chronically ill patients is discussed.

INSULOGENIC LIPODYSTROPHIES, THEIR RELATIONSHIP TO "BRITTLE" DIABETES AND TO INSULIN RESISTANCE. By Carlos P. Lamar, M.D. *J. A. M. A.* 142:1350-1353 (April 29) 1950.

In the series of 4 cases of insulin lipodystrophy presented there are 2 in which only atrophic lesions were present, and 2 in which the lesions were in hypertrophic and/or inflammatory stages, with atrophic areas elsewhere in 1 of these. In both types of cases insulin requirements seemed to have increased after the development of the local lesions, and local changes seemed to have interfered with absorption of the insulin.

Dr. Lamar concluded that insulin lipodystrophies are probably due to repeated trauma at the site of the injections of insulin in susceptible per-

sons, plus a personal factor, probably related to the chemistry of allergy and to metabolic disorders of hepatic function. He was of the opinion that in some instances insulogenic lipodystrophies of the atrophic type interfering with the continuous absorption of insulin from each depot injected may cause "insulin resistance." He also explained the probable mechanism of production of some cases of so-called "brittle" diabetes, with hyperglycemia and glycosuria occurring when some insulin remains unabsorbed for a certain period of time in the hypertrophic nodular type of insulogenic lipodystrophies, only to be added to the daily supply at a later date when it eventually becomes absorbed from these nodules. This would produce great variations in glycemia from extremely high to extremely low levels.

Systematic diversification of the site of insulin injections as a routine part of the patient's initial training is advocated. The "6 by 8" scheme is described as an easy method for instructing diabetic patients and impressing them with the importance of continuous systematic selection of insulin injection sites in order to prevent the occurrence of insulogenic lipodystrophies.

A ROENTGEN STUDY OF MUSCLE TUMORS PRIMARY IN THE LUNG. By Robert S. Sherman, M.D., and Bert H. Malone, M.D. *Radiology* 54:507-515 (April) 1950.

A series of 7 cases of myogenic tumor primary in the lung, studied roentgenologically and proved histologically at Memorial Hospital in New York, is presented. In these cases 4 of the tumors were myomas and 3 were myosarcomas, tumors which appear alike roentgenologically.

The authors noted that bronchogenic carcinoma of the nodular form, single carcinoma or sarcoma metastases, bronchial adenoma, tuberculoma, hamartoma, and cysts are chief among the conditions resembling myogenic tumors of the lung in certain cases. They concluded that while an unequivocal diagnosis of myogenic tumor is not possible roentgenologically, the possibility of the diagnosis is to be considered when a certain shadow pattern is encountered in the chest film.

THE TREATMENT OF BACTERIAL ENDOCARDITIS.

By Edward S. Orgain, M.D., F.A.C.P., and Charles K. Donegan, M.D. *Ann. Int. Med.* 32:1099-1113 (June) 1950.

A series of 138 cases of bacterial endocarditis, representing the total experience of the Duke Hospital with this disease, is presented. Analysis is made on the basis of three therapeutic periods: the presulfonamide period (1930 to 1937) with 41 cases and 1 survival; the sulfonamide period (1938 to 1943) with 41 cases and a recovery rate of 10 per cent; and the penicillin period (1944 to 1947) with 37 of 44 patients receiving penicillin and cure in 54 per cent.

The details of therapy are discussed with particular reference to daily and total dosage of penicillin, routes of administration, penicillin resistance, duration of therapy, and the causes of treatment failures. A comprehensive review of the literature and their own experience led the authors to conclude: (1) Adequate daily dosage of penicillin is of paramount importance and depends to a large extent upon the sensitivity of the organism, which may be determined by preliminary *in vitro* studies. If the organism proves sensitive, therapy should begin at not less than 500,000 units of penicillin per day, and if resistant, not less than 1,000,000 units per day. (2) The various technics of administration have not demonstrated any individual superiority. (3) Anticoagulant therapy has not altered the final therapeutic results and is potentially dangerous. (4) The duration of treatment should extend for at least four to six weeks initially and longer if a relapse occurs.

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February Anniversaries

In reviewing historic medical events which happened in the month of February, we find that on Feb. 11, 1752, the first patients were admitted to America's first voluntary hospital, Pennsylvania Hospital of Philadelphia, under the direction of Benjamin Franklin and Thomas and Phineas Bond. In his newspaper, by personal solicitation and also by petitioning the assembly, Mr. Franklin assisted in raising funds for the hospital. "I do not remember," he wrote, "any of my political manoeuvres the success of which . . . gave me more pleasure."

On Feb. 13, 1843, Oliver Wendell Holmes read his epoch-making essay on the "Contagiousness of Puerperal Fever." In it he traced the transmission of the fever from cases of erysipelas and from a physician who had conducted a postmortem examination. Dr. Holmes wrote: "No negative facts, no passing opinions, be they what they may or whose they may, can form any answer to the series of cases now within the reach of all who choose to explore the records of medical science."

En route to England on Feb. 21, 1941, Sir Frederick Grant Banting of Toronto, Canada, died as the result of an airplane crash. Years earlier, while writing a lecture on diabetes, Dr. Banting had conceived a method for preparing an active extract of the islands of Langerhans. He had then obtained the support of Professor J. J. R. Macleod of the University of Toronto, with the result that insulin was isolated and the treatment

of diabetes mellitus revolutionized. Drs. Banting and Macleod were given the Nobel Prize in 1923, an award which they divided with their co-workers, C. H. Best and J. B. Collip.

Showered with honors, Dr. Banting remained the modest, shy, doggedly persevering scientist. These words reveal his philosophy of life: "I am a firm believer in the theory that you can do or be anything that you wish in this world, within reason, if you are prepared to make the sacrifices, think, and work hard enough and long enough."

Under Two Flags "Mobilize for Mercy"

Beside the Stars and Stripes flies the Red Cross flag of mercy — the two as inseparable in national emergencies as on the battlefield. When war erupts, when nature goes on a rampage, we Americans naturally turn to our American Red Cross, which, in the words of General Eisenhower, is "the warm heart of a free people."

"Mobilize for Mercy" is the slogan for the March 1951 campaign. This year the Red Cross asks every one of us to help supply the funds badly needed for its expanded work for the armed forces and civil defense, and also to aid in recruiting volunteers to make this work possible. Not only must it make provision for continuing its regular work, but it must accept heavy new responsibilities.

The Secretary of Defense has designated the American Red Cross the official blood procurement agency for the needs of the armed forces.

The National Security Resources Board also has requested that this organization coordinate a nationwide blood program for civil defense. With these new tasks added to its regular peacetime program, it is taking over the responsibility for procuring large quantities of blood.

Another herculean undertaking confronts the "Old Reliable," as the Red Cross appropriately has been called. Again at the direction of the National Security Resources Board, it must train as many as 20 million persons in first aid, including all civil defense workers. Success hinges upon cooperation of the public, both in filling and helping to instruct the classes.

Recruiting and training great numbers of women in home nursing courses and as nurse's aides is a third new responsibility delegated to the Red Cross by the National Security Resources Board. It is anticipated that in an emergency hundreds of thousands of women will have to give nursing care to their families and their neighbors. More hundreds of thousands will be needed to serve as nurse's aides in hospitals, at blood centers, and in emergency shelters. It is planned to offer home nursing instruction to 700,000 persons this year.

This expanded program calls for millions of volunteers—blood donors, nonprofessional workers in hospitals, drivers for Motor Service, and other workers—to meet all local chapter needs. If the Red Cross is to realize adequately on its long history of trained volunteer service, if the Red Cross know-how is to be utilized fully in 1951, this indispensable American institution must have generous support from citizens everywhere in all walks of life. How much will you give to keep America's other flag flying?

No Bargain, Indeed! Labor Speaks Out

"I am against socialized medicine. So is the organization which I have the honor of heading. . . Any way you look at it, socialized medicine is no bargain and the carpenters want none of it." In these words William L. Hutcheson, General President of the United Brotherhood of Carpenters & Joiners of America and Vice President of the American Federation of Labor, expressed the position of his labor group on the National Health Program. His message was to the House of Delegates of the American Medical Association and the Third Annual Conference of the A. M. A. National Education Campaign, meeting jointly in

Cleveland last December. This action marks the first time a major labor organization has spoken out against socialized medicine.

As refreshing as an ocean breeze was the forthright address of this outstanding labor leader, who saluted the physicians of this country not only as doctors but as crusading citizens, willing to fight for their convictions, beside whom he was happy to take his stand. Not averse to saving a dollar, he, in fact, likes to get as much for his money as the next man. That, he explained, is one of the reasons why he is opposed to socialized medicine. "It looks cheap the way the backers present it, but when you dig down under the fancy layer of propaganda frosting you find that it can be mighty expensive. The British people have already discovered this fact."

He cited data from the International Labour Office stating that the 1950-1951 estimated cost of Britain's National Health Service is 484 million pounds, in contrast to an estimated 167 million pounds a year in 1946 when the health legislation was passed. Too, for all the planning that has been done, there are twice as many patients per doctor in London's inner East End as in certain wealthier districts, reflecting an uneven distribution of doctors which only compulsion can remedy.

Mr. Hutcheson observed that when government is given authority to tell one group or one profession where and how its members are to work, no other group or profession can be safe for long. Wisely he reasoned:

If the day ever comes to America when Uncle Sam usurps the power to dictate to doctors under a health plan, it will be a sad day for carpenters. Adequate housing is still an unsolved problem in this country, especially for the poor. If it is logical to nationalize the medical profession to get more medical service for the poor, it is equally logical to nationalize the home construction industry to get roofs over the heads of the lower income groups.

I do not know much about doctors, but I know quite a bit about carpenters. They are an independent lot. They want to work where and how they please. The first bureaucrat who told a carpenter he had to work in Little Rock when he wanted to work in Lancaster would be gumming his food for lack of teeth. Carpenters want to be free agents; free to work where they want to; free to negotiate the terms of their wages and working conditions through collective bargaining; yes, even free to leave the industry and try their luck at something else if the spirit moves them.

They will retain these freedoms only so long as all other groups retain theirs. Socialization is like a wolf with a tapeworm; once it starts gnawing, it never can stop. Socialized medicine would only be the first bite out of our free enterprise system; it would not be many years before the carpenters would be feeling the teeth of socialization on the seats of their overalls. . . .

Perhaps if human nature were less ornery and less

avaricious, an idealistic health program might work out all right. But so long as people have preferences, so long as Park Avenue has more appeal than Hell's Kitchen, there will be an uneven distribution of doctors under any plan that does not contain compulsion. And once compulsion enters the picture, the rights and freedoms of all citizens stand in jeopardy. To me, it is as simple as that.

The medical profession warmly welcomes Mr. Hutcheson and his carpenters as co-laborers in the cause of freedom. Congratulations to him for his perspicacity, forthrightness and courageous leadership.

Physicians, the Press and the Public

It is an ironic fact that the medical profession, which has done so much to deserve the gratitude of mankind, is now fighting a battle for survival. Inadequate public relations — failure of the profession to get the story of its accomplishments across to the public — must be largely responsible for the profession's plight.

The public's growing interest in medical affairs now presents an opportunity for getting the profession's message to the people. Great care must be exercised, however, to release the right type of news and to present it accurately. The honest newspaper man and physician are quite aware of the sharp line that must be drawn between education of the public and use of public information to promote the practice of an individual physician.

In the Chicago Medical Society Bulletin for June 17, 1950, Arthur J. Snider, science editor of the Chicago Daily News, ably discusses problems of medical-press relations. He warns against news distortion and premature publication, and shows the need for presenting research in proper perspective.

The National Association of Science Writers is to be commended for its efforts to obtain better reporting of medical science news. Each member of the association is proud of his reputation and endeavors to enhance it in the eyes of the medical profession.

The section on educational information in the revised ethical code encourages members of the medical profession "to write, act or speak for general readers or audiences." The physician should, therefore, discard his historic antipathy toward publicity and cooperate wholeheartedly in creating better public relations between the profession and the public.

Hospital Firsts

Joseph Nathan Kane in "Famous First Facts" and "More First Facts" presents "Famous Hospital Firsts:"

The first voluntary hospital in America was the Pennsylvania Hospital, established in Philadelphia in February 1752.

The first marine hospital was the Norfolk Naval Hospital at Norfolk, Va., deeded to the United States government on April 20, 1801, by Governor James Monroe of Virginia.

The first children's hospital was opened in 1854 in New York City and was known as "The Nursery and Child's Hospital."

The first woman's hospital was Woman's Hospital of New York City. In 1855 thirty women formed the "Women's Hospital Association" and adopted a constitution. There was opened on May 4, 1855 at Madison Avenue and Twenty-Ninth Street the first hospital in the world founded for the exclusive use of women.

The first babies' hospital, designed exclusively for infants, was Babies Hospital of the City of New York, chartered June 23, 1887.

The first cancer hospital was the New York Cancer Hospital, which was opened Dec. 6, 1887.

The first leper hospital was the Louisiana Leper Home at Carville, La., founded in 1894 by an act of the Louisiana legislature. The home was purchased by the federal government in 1921 and is now operated by the United States Public Health Service.

The first state tuberculosis sanatorium was the Rutland (Mass.) Sanatorium, opened Sept. 23, 1898.

Not included in Mr. Kane's list and known to but few persons is the fact that the first hospital building in territory now comprising the United States was an institution of "decent appointments" with six beds, named Santa Barbara and constructed in St. Augustine by Spanish Governor Canço in the year 1599. It was constructed "after the monks, whose monastery burned March 14, 1599, had moved into the hermitage of Nuestra Señora de la Soledad, where the hospital had previously been."

The editorial staff of The Journal plans to present more about this Florida hospital of three and a half centuries ago in a later issue.

Physicians and Pharmacists Get Together

Getting physicians and pharmacists together as a body through organization has been needed for a long time. How to go about meeting this need was a problem which defied solution. The physician did not like to be told that he was remiss in this particular, and neither did the pharmacist.

During the last year, however, real progress has been made. The threat of Socialism, the rising cost of medical care, and an aroused public have increased the need for cooperation between physicians and pharmacists.

Dr. Henry J. Peavy, Chairman of the Committee on Interrelationship of the Florida Medical Association, and Dr. Perry A. Foote, Dean of the College of Pharmacy of the University of Florida and Director of its Bureau of Professional Relations, are strong proponents of cooperation between the professions. Their efforts indicate, however, that the task probably should not be undertaken primarily from the state level.

During the last few months several local organizations, stimulated by the Bureau of Professional Relations of the College of Pharmacy, have formed joint committees on interprofessional relations. A few local physicians who are deeply interested in this program are asking their county societies to appoint three physicians from their respective groups to serve in this capacity. One physician was so interested that he asked permission to speak before the pharmacy district group on the importance of such cooperation between physicians and pharmacists.

It is highly desirable that, in the immediate future, local groups have committees on interprofessional relations actively engaged in solving the problems in their respective areas. These local committees then could take their more difficult problems to a committee organized on a statewide basis. Organization in this manner should bring real cooperation between members of the two professions in solving their mutual problems and should serve as a constructive force for the betterment of both physicians and pharmacists.

Your March Journal will contain the complete program for the Seventy-Seventh Annual Meeting at Hollywood — April 22-25.

YOUR BLUE SHIELD

For Prompt Payment

The primary objective of the Blue Shield Case Department is to extend benefits to subscribers and to make settlement to participating physicians on all authentic cases in the fastest and most efficient way possible.

The participating physician benefits by the prompt disposition of Blue Shield cases, whether the case be approved for payment or disapproved. It goes without saying that the physician benefits by the prompt payment on a Blue Shield case, however, when a case must be disapproved by the Plan and the physician is promptly notified, he benefits by this action, insofar as he is notified in sufficient time to make other financial arrangements with the patient.

Complete Information Necessary

The one determining factor in the prompt disposition of a Blue Shield case is the completeness with which the Doctor's Service Report is filled out. A Doctor's Service Report containing all the necessary information can be immediately processed, but a report lacking the required information must be "pending" for further information and usually involves much time-consuming correspondence between the Plan and the physician, causing a delay in the final action taken on the case.

Of particular importance in completing the Doctor's Service Report are the number of the subscriber's contract, code number for the surgical procedure performed and the participating physician's code number. A numerical system of maintaining its records was adopted by the Plan in the interest of greater efficiency, economy and speed, and while use of numbers facilitates the processing of a case, the omission of these numbers very often makes it impossible to process a case without entering into correspondence with the doctor.

All Information Important

Although much of the information required on the Doctor's Service Report may not appear to be pertinent to the case in question, it should be pointed out that the Doctor's Service Report serves several purposes. Its primary purpose is for the reporting of services rendered Blue Shield members, however, it is also used as a source of information for statistics of all kinds necessary for the management and future planning of Blue Shield and therefore should be complete in every detail.

STATE NEWS ITEMS

Dr. George F. Schmitt of Miami recently addressed the local obstetrical and gynecological society on the subject of diabetes in pregnancy.

Dr. William H. McCullagh of Jacksonville has been elected vice-president of the Southern Psychiatric Society.

Dr. Jere W. Annis of Lakeland recently addressed the local Rotary Club on the subject of heart diseases.

Dr. J. K. David, Jr., of Jacksonville has resumed his practice following visits to clinics in New York City in December.

Dr. Walter W. Sackett, Jr., of Miami, Florida delegate to the American Academy of General Practice, has been appointed to that Society's nominating committee.

Dr. Wilson T. Sowder of Jacksonville was a featured speaker at a meeting of the Duval Chapter of the Florida Heart Association in November.

Dr. Bernard J. McCloskey of Jacksonville recently addressed the local Catholic Woman's Club on the subject "The Challenge of Cancer."

Dr. Erasmus B. Hardee of Vero Beach, chairman of the committee on Tuberculosis and Public Health, recently addressed a meeting of the State Tuberculosis Board held in Orlando. Dr. Hardee's discussion was based on the results of a questionnaire prepared by the Florida Medical Association and sent to all Florida hospitals.

The National Conference on Rural Health, sponsored by the A.M.A. Committee on Rural Health, will hold its sixth national conference in Memphis, February 23-24, in the Peabody Hotel.

The program is built around the planning and organization of health councils. The entire program will consist of general sessions rather than a series of small groups as in previous conferences. For additional information, write Dr. F. S. Crockett, 300 Main St., Lafayette, Indiana.

Any member contemplating attending this conference is requested to make reservations with the Peabody Hotel.

A copy of the 1951 F.M.A. Directory has been mailed to each active member of the Association.

Dr. Marlin C. Moore was the guest speaker at the November meeting of the Jacksonville Woman's Club.

Dr. John D. Milton of Miami has been appointed by President White to replace Dr. W. Duncan Owens, formerly of Miami Beach, on the Board of Governors. Dr. Owens recently resigned, having moved from the state.

Dr. Russell B. Carson of Ft. Lauderdale has been appointed by President White to replace Dr. W. Duncan Owens of Miami Beach, recently resigned, on the Committee on Legislation and Public Policy.

Dr. Fred E. Brammer of Dania on November 13 talked to the local Rotary Club on the history, symptoms, diagnosis and treatment of diabetes.

The following members of the Association attended the A.M.A. Clinical Session at Cleveland, December 5-8: Drs. Richard A. Mills, Ft. Lauderdale; John M. Malone, Green Cove Springs; Louis J. Polskin, Lakeland; Harry F. Rolfes, Lake Wales; Reuben B. Chrisman, Jr., Joseph S. Stewart, Miami, and representatives to A.M.A. House of Delegates Homer L. Pearson, Jr., Miami, and Louis M. Orr, II, Orlando.

Dr. Joseph S. Stewart of Miami, chairman of the Committee on Public Relations, represented the Association at the annual A.M.A. Public Relations Conference held in Cleveland, December 3-4. Others attending this conference include Dr. Homer L. Pearson, Jr., Dr. Reuben B. Chrisman, Jr., and Mr. W. Harold Parham.

Dr. Joseph S. Stewart of Miami officially represented the Association at the A.M.A. National Education Campaign Conference held in Cleveland, December 7. A.M.A. delegates Drs. Homer L. Pearson, Jr. and Louis M. Orr, II; Dr. Reuben B. Chrisman, Jr., and Mr. W. Harold Parham also were in attendance.

The American College of Allergists will hold its seventh annual meeting at the Edgewater Beach Hotel, Chicago, February 12-14. Numerous sectional meetings will be held on various aspects of allergy under the leadership of eminent allergists from the East and Midwest.

Immediately preceding the annual meeting, on February 9-11 the College's annual post collegiate instructional course will be held. For further information, write Fred Wittich, M.D., Secretary-Treasurer, American College of Allergists, LaSalle Medical Building, Minneapolis, Minnesota.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Floyd L. Pichler of Jacksonville announce the birth of a daughter, Deanna Lynn, on Nov. 23, 1950.

Dr. and Mrs. Donald P. White, Jr., of Jacksonville announce the birth of a daughter, Sherry, on Dec. 3, 1950.

Dr. and Mrs. George P. Beach of Jacksonville announce the birth of a son on Dec. 1, 1950.

Deaths — Members

Lippincott, Leon S., Daytona Beach	Nov. 25, 1950
Ely, Reuel A., Tampa	Dec. 28, 1950
Horne, Lester W., St. Petersburg	Dec. 29, 1950

Deaths — Other Doctors

MacConnell, John W., Davidson, N. C.	Sept. 26, 1950
O'Hara, Fred S., Springfield, Ill.	Oct. 1, 1950

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Atkinson, Horace D., St. Petersburg
Groskloss, Howard H., Miami
Hernandez, M. S., Miami
Howard, Harvey J., Clearwater
Humes, Karl T., Bushnell
Karaphillis, John T., Clearwater
McCorkle, James K., St. Petersburg
Manheimer, Leon H., Miami Beach
Ruhl, Frank G., Jr., Miami
Spoto, Joseph S., St. Petersburg
Sterman, Irving, Miami
Wager, Harold E., Panama City

COMPONENT SOCIETY NOTES

Alachua

At the regular monthly meeting of the Alachua County Medical Society officers for 1951 were elected as follows: Dr. James M. McClamroch, president; Dr. Henry J. Babers, Jr., president-elect; Dr. F. Emory Bell, vice-president, and Dr. Henry H. Graham, secretary-treasurer, all of Gainesville.

Bay

The 1951 officers of the Bay County Medical Society were elected at the regular December meeting. They are Dr. James M. Nixon, president; Dr. Amsie H. Lisenby, vice-president, and Dr. Harold E. Wager, secretary-treasurer, all of Panama City.

Brevard

At the regular December meeting of the Brevard County Medical Society officers were elected for the year 1951. Dr. Allen E. Kuester of Cocoa was elected president, Dr. James A. Sewell of Melbourne was elected vice-president, and Dr. Theodore J. Kaminski of Melbourne was re-elected secretary-treasurer.

Broward

Dr. M. Austin Lovejoy was elected president of the Broward County Medical Society for 1951 at the regular December meeting. Other officers for the year include Dr. Lloyd U. Lumpkin, president-elect; Dr. Frederick J. Driscoll, vice-president; Dr. Thomas L. Roberts, Jr., secretary, and Dr. Julius F. Boettner, treasurer. All 1951 officers are from Ft. Lauderdale.

Columbia

The list of 1951 officers for the Columbia County Medical Society appeared in the January issue of The Journal.

Dade

Dr. Jack Q. Cleveland of Coral Gables will serve as president of the Dade County Medical Association for 1951. Dr. Ralph S. Sappenfield of Miami was elected president-elect. Other officers for the coming year which were elected at the regular December meeting include Dr. Charles R. Burbacher of Coral Gables, vice-president; Dr. Reuben B. Chrisman, Jr., of Miami, secretary, and Dr. Raymond L. Evans of Miami, treasurer.

DeSoto-Hardee-Highlands-Glades

Officers of the DeSoto-Hardee-Highlands-Glades County Medical Society for 1951 are Dr. Hubert W. Coleman of Avon Park, president; Dr. Carl J. Larsen of Avon Park, vice-president, and Dr. Edwin C. Northup of Avon Park, secretary-treasurer.

Duval

At the regular December meeting of the Duval County Medical Society, the 1951 officers were elected. They are Dr. Charles F. Henley, president; Dr. Ferdinand Richards, president-elect; Dr. John F. Lovejoy, vice-president; Dr. C. Burling Roesch, secretary, and Dr. G. Dekle Taylor, treasurer, all of Jacksonville.

Escambia

Officers elected to serve the Escambia County Medical Society for the year 1951 at the December meeting are Dr. Lee Sharp, president; Dr. Alvin L. Stebbins, vice-president, and Dr. Arthur J. Butt, Jr., secretary-treasurer, all of Pensacola.

Franklin-Gulf

At its regular December meeting, the Franklin-Gulf County Medical Society elected the following officers to serve during 1951: Dr. William P. Blackmon, Apalachicola, president; Dr. James A. Steely, Apalachicola, vice-president; Dr. Albert L. Ward, Port St. Joe, secretary-treasurer.

Hillsborough

The 1951 officers of the Hillsborough County Medical Association were elected at the regular meeting in December. They are Dr. R. Renfro Duke, president; Dr. Sherman B. Forbes, president-elect; Dr. Edward F. Carter, Sr., vice-president; Dr. James N. Patterson, secretary, and Dr. Joseph A. Pendino, treasurer, all of Tampa.

Indian River

The following members were elected officers for 1951 at the regular meeting of the Indian River County Medical Society in December: Dr. Erasmus B. Hardee, president; Dr. James C. Robertson, vice-president, and Dr. William L. Fitts, 3rd, secretary-treasurer, all of Vero Beach.

Jackson

The following officers for 1951 were elected by the members of the Jackson County Medical Society at the December meeting: Dr. Jasper B. Dowling of Altha, president; Dr. William R. Wandek, Marianna, vice-president, and Dr. Francis M. Watson of Marianna, secretary-treasurer.

Lake

At the December meeting of the Lake County Medical Society, officers for 1951 were elected. Dr. H. Durham Young, Jr., of Leesburg was elected president, Dr. Louis R. Bowen of Eustis, vice-president, and Dr. Lawton F. Douglass of Eustis, secretary-treasurer.

Lee-Charlotte-Collier-Hendry

Officers elected to serve the Lee-Charlotte-Collier-Hendry County Medical Society during 1951 include: Dr. William H. Grace, president; Dr. Ernest Bostelman, vice-president, and Dr. Angus D. Grace, secretary-treasurer, all of Ft. Myers.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. John T. Benbow of Chattahoochee is the newly-elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. Ernest W. Ekermeier of Tallahassee was elected vice-president and Dr. Charles F. James, Jr., of Tallahassee was elected secretary-treasurer.

Manatee

At the regular December meeting of the Manatee County Medical Society, the following officers were elected for 1951: Dr. Roderic O. Jones, president; Dr. John E. Granade, vice-president, and Dr. Marjorie L. Warner, secretary-treasurer, all of Bradenton.

Marion

The 1951 officers of the Marion County Medical Society were elected at the regular December meeting. Dr. Richard C. Cumming was re-elected president, and Dr. Bertrand F. Drake was re-elected secretary-treasurer. Dr. John P. Moore was elected vice-president. All officers reside in Ocala.

Monroe

Dr. Ralph Herz of Key West is the newly-elected president of the Monroe County Medical Society and will serve during the year 1951. Dr. Herman K. Moore of Key West was elected secretary-treasurer.

Nassau

Dr. David G. Humphreys was re-elected president of the Nassau County Medical Society for 1951 at the December meeting. Dr. Benjamin F. Dickens was elected vice-president and Dr. John W. McClane was re-elected secretary-treasurer. All three officers are from Fernandina.



a. Ulcerative amebiasis during Diodoquin therapy. In this patient with severe hemorrhage, edema and necrosis, the ulcers show healing, with many scars. No active lesions are seen.



Photographs courtesy of Louis H. Block, M. D., Chicago

b. Three months later, after continuing Diodoquin therapy, extensive scarring indicates healing. Inflammation is further reduced and only superficial areas of inflammation remain.

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1. Johnson, S. K.: Mississippi Doctor 27:69 (July) 1949.

2. Merritt, W.: J. Florida M. A. 35:351 (Dec.) 1948.

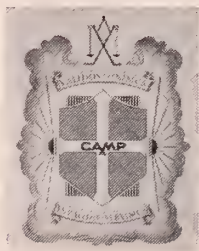


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Pasco-Hernando-Citrus

The following officers for 1951 were elected at the regular December meeting of the Pasco-Hernando-Citrus County Medical Society: Dr. Gail M. Osterhout of Inverness, president; Dr. Donald G. Bradshaw of Zephyrhills, 1st vice-president; Dr. George R. Creekmore of Brooksville, 2nd vice-president, and Dr. W. Wardlaw Jones of Dade City, secretary-treasurer.

Pinellas

The list of officers who will serve the Pinellas County Medical Society during 1951 appeared in the December Journal.

The regular monthly meeting of the Society was held on January 8 at the Detroit Hotel in St. Petersburg. Dr. Richard H. Sinden of St. Petersburg presented a scientific paper on "Diabetic Complications."

Polk

The following officers for 1951 were elected by the membership of the Polk County Medical Society at the December meeting: Dr. John W. Vaughn, Lakeland, president; Dr. Robert J. Jahn, Winter Haven, vice-president, and Dr. Jere W. Annis, Lakeland, secretary-treasurer.

Putnam

At its regular meeting in December, the Putnam County Medical Society held its annual election of officers. Those elected to office were Dr. Claude M. Knight of Palatka, president, and Dr. James W. Brantley of Grandin, secretary-treasurer.

St. Johns

At the regular December meeting of the St. Johns County Medical Society, the following officers were elected: Dr. Joseph A. Shelley, St. Augustine, president; Dr. A. Clark Walkup, St. Augustine, vice-president; Dr. James J. DeVito, St. Augustine, secretary, and Dr. George C. Hopkins, St. Augustine, treasurer.

St. Lucie-Okeechobee-Martin

The newly-elected officers of the St. Lucie-Okeechobee-Martin County Medical Society are as follows: Dr. Julian D. Parker of Stuart, president; Dr. Richard F. Sinnott, Ft. Pierce, vice-president, and Dr. Adrian M. Sample of Ft. Pierce, secretary-treasurer.

Advertisement



From where I sit by Joe Marsh

Watch Out For The "Blind Spots"

Stopped by Squint Miller's farm the other day and saw a vinegar bottle in his kitchen with an oversized cucumber inside it. The cucumber filled the whole bottle.

"What's a cucumber doing in there?" I asked him. "That's my 'blind spot' reminder," says Squint. "My grandmother kept one in her kitchen to remind her to take stock of herself now and then.

"I slipped the bottle over the cucumber when it was just starting to grow on the vine," he went on. "And like certain viewpoints we acquire, not noticed, it just grew and grew—now it's there to stay."

From where I sit, we could all take a cue from Squint and watch out for our own "blind spots." Sometimes we impose our views on our neighbor without thinking of his rights as an American—his right to follow his profession where and how he chooses, or say, his right to enjoy a glass of beer. No more "blind spots" if we keep our eyes—and minds—open!

Joe Marsh

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Orange

Officers elected to serve the Orange County Medical Society during 1951 include: Dr. Fred Mathers, president; Dr. Carl S. McLemore, president-elect; Dr. Merrill Wattles, vice-president; Dr. Gerald W. Jones, secretary, and Dr. Joseph C. Hayward, treasurer, all of Orlando.

Palm Beach

Dr. Ralph M. Overstreet, Jr., of West Palm Beach will serve as president of the Palm Beach County Medical Society during 1951. Officers elected to serve with Dr. Overstreet at the regular December meeting include Dr. Cecil M. Peek of Belle Glade, president-elect; Dr. Alvin E. Murphy of Palm Beach, vice-president; Dr. Lorenzo James of West Palm Beach, secretary, and Dr. Frederick K. Herpel of West Palm Beach, treasurer.

Sarasota

Dr. Sherrel D. Patton of Sarasota is the newly-elected president of the Sarasota County Medical Society. Other officers for 1951 include Dr. Henry G. Morton, vice-president, and Dr. Millard B. White, secretary-treasurer, also of Sarasota.

Seminole

At its regular business meeting in December, the Seminole County Medical Society held its annual election of officers. Those elected to office were Dr. Thomas F. McDaniel of Sanford, president; Dr. Wade H. Garner of Sanford, vice-president, and Dr. Frank L. Quillman, Sanford, secretary-treasurer.

Suwannee

Officers of the Suwannee County Medical Society for 1951 were elected at the December meeting. Dr. Irby H. Black of Live Oak was re-elected president and Dr. J. Dillard Workman of Live Oak was re-elected secretary-treasurer.

Taylor

Officers elected to serve the Taylor County Medical Society during 1951 are: Dr. Ralph J. Creene of Perry, president, and Dr. Walter J. Baker of Foley, secretary.

Volusia

The Volusia County Medical Society elected officers for 1951 at its December meeting. Dr. Peter A. Drohomer of Daytona Beach was elected president, Dr. Robert O. Burry of DeLand was elected vice-president, and Dr. Robert L. Miller of Daytona Beach was re-elected secretary-treasurer.

Walton-Okaloosa

At the regular December meeting, the Walton-Okaloosa County Medical Society elected officers to serve during 1951. Dr. Arthur G. Williams, Jr., Valparaiso, was elected president, and Dr. Ralph B. Spires, DeFuniak Springs, was elected secretary.

Washington-Holmes

New officers who will serve the Washington-Holmes County Medical Society during 1951 include Dr. N. J. Dawkins of Vernon, president, and Dr. Bayllye W. Dalton of Chipley, secretary.

OBITUARIES

John Alfred Beals

Dr. John A. Beals of Jacksonville died at St. Luke's Hospital in that city on Nov. 6, 1950 after a lingering illness. Death came on the eve of his sixtieth birthday.

The son of John and Dora Fondrey Beals of Westfield, Ind., Dr. Beals was born there Nov. 7, 1890. After receiving his academic education, he was associated for a brief period with his father in managing a large glass manufacturing business. In 1913 he entered the Tulane University of Louisiana School of Medicine and received the degree of Doctor of Medicine there in 1919. During World War I, he served in the medical reserve.

After training at various hospitals under outstanding radiologists of his time, Dr. Beals served as radiologist at Riverside Hospital in Jacksonville from 1923 to 1928. He then went to Chattanooga, Tenn., to practice, but returned to Jacksonville in 1938 to become chief radiologist at St. Luke's Hospital. He held this position until his death, at which time he was also chief of the medical staff there and a member of the executive staff of the Duval Medical Center. Locally, he was a Kiwanian and a member of the First Christian Church.

Dr. Beals was a past treasurer and president of the Duval County Medical Society; a member of the Florida Medical Association, the American Medical Association and the Southern Medical Association; a certificant of the American Board of Radiology; a fellow, councillor and member of the Board of Chancellors of the American College of Radiology; a member of the Radiological So-

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting February 19, March 5, March 19. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 5, April 2, April 30. Surgical Anatomy & Clinical Surgery, Two Weeks, starting February 19, March 19, April 16. Surgery of Colon & Rectum, One Week, starting March 5, April 9. Basic Principles in General Surgery, Two Weeks, starting April 2. Gallbladder Surgery, Ten Hours, starting April 23. Fractures & Traumatic Surgery, Two Weeks, starting March 19.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 19, March 19. Vaginal Approach to Pelvic Surgery, One Week, starting March 5, April 2.

OBSTETRICS—Intensive Course, Two Weeks, starting March 5, April 2.

MEDICINE—Intensive General Course, Two Weeks, starting April 23. Gastro-enterology, Two Weeks, starting May 14. Gastroscopy, Two Weeks, starting March 5. Electrocardiography & Heart Disease, Two Weeks, starting March 19.

PEDIATRICS—Intensive Course, Two Weeks, starting April 2. One Year Full Time Course starting July 2. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 16. Cystoscopy, Ten Day Practical Course, every two weeks.

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ciety of North America; and a past secretary, vice president and president of the Florida Radiological Society.

Surviving are the widow, Mrs. Harriet Christian Beals; one daughter, Miss Paloma Beals of Jacksonville; two sons, Capt. John Thomas Beals of Biloxi, Miss., and Daniel F. Beals of Jacksonville; his mother, Mrs. Dora Fondrey Beals of Westfield, Ind.; and three grandchildren, John M., Catherine A. and Christopher Beals.

Miriam Magruder Drane

Dr. Miriam M. Drane of St. Petersburg died in a hospital in that city on Nov. 28, 1950. She was 57 years of age.

Born at Lone Station, Miss., on Jan. 7, 1893, Dr. Drane received the Bachelor of Arts degree from the University of Tennessee in 1914, and in 1926 was awarded the degree of Doctor of Medicine from the College of Medicine of that institution. She also had training at the University of Chicago and Michael Reese Hospital in Chicago.

After receiving her medical degree, Dr. Drane was associated in the practice of medicine for a

time with Dr. Henry Rudner in Memphis. In 1929 she established her own office there, practicing internal medicine and majoring in allergy. She was licensed in Florida in 1940. Locating in St. Petersburg in 1943, she practiced there the remaining years of her life. Locally, she was on the staff of both St. Anthony's and Mound Park hospitals. She held membership in the Woman's Auxiliary of St. Anthony's Hospital, the Zonta, Pan-Hellenic and Business Women's clubs and the Baptist Church.

Dr. Drane was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association. In 1949 she was elected an alternate delegate to the Florida Medical Association from the Pinellas County Medical Society, and in recent years had been a contributor to the Journal of the Florida Medical Association.

Survivors include four brothers, Walter Earl Drane, Forest, La., Hayward Drane, Natchez, Miss., T. G. Drane, Texas, and Herbert Drane, Memphis, Tenn.; two sisters, Mrs. T. A. Wood and Miss Vera L. Drane of Gulfport, Miss.; and one cousin, Miss Ellen Leech of St. Petersburg.



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BOOKS RECEIVED

PHYSICIAN TO THE WORLD, THE LIFE OF GENERAL WILLIAM C. GORGAS. By John M. Gibson. Price, \$4.50. Pp. 315. Durham, N. C.: Duke University Press. 1950.

"The man who made the building of the Panama Canal possible," William Crawford Gorgas, is most noted for the successful battle he waged against yellow fever, but more interesting to the reader perhaps is the story behind his fame. Drawn from personal correspondence of Gorgas and his family, here is a heart-warming story of a little boy who shivered in the early morning air of Charleston as he watched the first shell explode over Fort Sumter; of a young man whose determination to enter the Army led him to medical college because the only road left open for entrance was through the Medical Department; of an Army physician who, disregarding personal danger, deliberately entered a yellow fever ward to study the disease; and of the romance of a doctor who married one of his patients. Here is the success story of a fighter for whom ridicule gave way to praise and who became Surgeon General of the United States Army during World War I.

Gorgas' conquest of yellow fever has overshadowed his brilliant work in the curbing of malaria, dysentery, typhoid and pneumonia. Although his name is not so familiar to this generation, Gorgas was known throughout the world before his death in 1920 for his work in Cuba, Panama, South America, Africa and Europe. Many widely accepted sanitation principles of today were laid down by him. This biography makes interesting and entertaining reading.

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What Every Doctor Should Know

There is contagion in the grin and fellowship that spreads with the wish for a Happy New Year because everyone is looking in the same direction. A beginning is good. Its potentialities, undeveloped and filled with hope, make for the gaiety and noise symbolic of this season.

A Happy New Year. How many facets it reveals when individualized. What brings joy to one means little to another. The wish is just a beginning; a stepping stone to the various paths we each must follow if we want to make our wish come true. For instance doctors, to have a good year, must grow in unity and reinforce the preservation of the ideals which wave like a flag of independence over the profession. They must maintain their freedom to practice medicine without regimentation of their services. They must have closer understanding of the people, and consideration and respect by the people.

Such broad stepping stones cover a lot of ground and indicate many paths of travel. No progress along these roads can be made with wishes. So, busy doctors, help us recruit your wives. We cordially invite non-auxiliary members to join us in contributing to the realization of your wish. We have the plan and the materials with which to work. We need more workers. They can bring their interest in your welfare as a token contribution.

The work reveals itself to the worker. The fields that are plowed and planted by the sowers of seed look barren and uninteresting to indiffer-

ent travelers who glance at the toilers in passing, and wonder what keeps them so long in the field. Because some took different paths last year they didn't know the disaster that threatened their land nor did they see the hours spent in prevention and salvage. A veritable army of volunteer workers tilled that ground and in the place of chaff was planted wheat. There is pride of accomplishment in the hearts of those who stay in the field, and visions of growth which only those who plant the seed can realize.

In one small Auxiliary, a group of twenty-three doctors' wives were asked to list the various organizations to which they belonged. The number totaled one hundred and thirty-five. We plant the seeds of education. Think of the value of one hundred and thirty-five organizations receiving accurate information on why a doctor resists compulsion in his practice of medicine. Think of the damage caused by ignorance of medical interests by a doctor's wife when she participates in other organizations.

We enlist the wives to study and become informed because the planter has to know the nature of his crop. Education is not a hardy plant. The ground must be properly prepared to encourage the growth. We can't be indifferent because the sowers of dragon seed are zealous and are interested in our ground.

We want more to discover that our work with ideas and principles can be interesting. In our allegorical "garden club" we plant, we weed and we reap. With enough hands sowing the seeds of public relations, good will and education we will reap a harvest of dignity in which even our children can share in a happier new year.

Mrs. C. Robert DeArmas,
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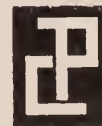
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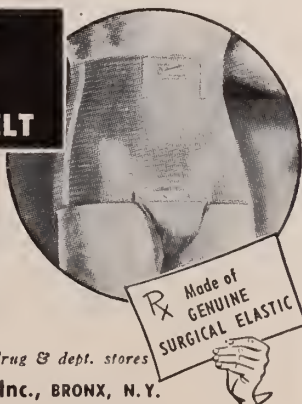
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1. LEHR, D. (1950), RELATIVE MERITS OF COMMONLY USED SULFONAMIDE DRUGS AS COMPONENTS OF MIXTURES, N. Y. STATE J. MED., 50:1361, JUNE.



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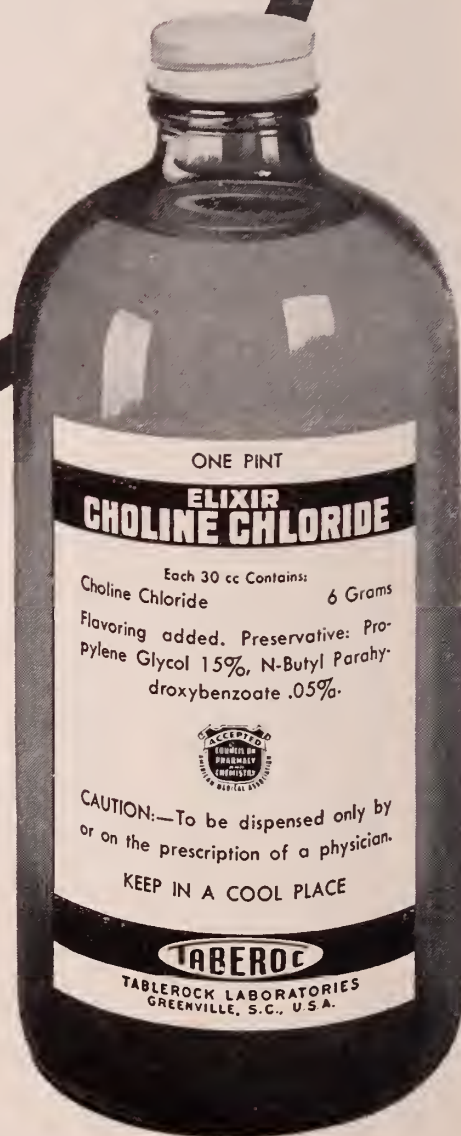
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Pensacola, 1951
B-Northeast	Cleland D. Cochran, Daytona Beach	Eugene G. Peek, Jr., Ocala	Orlando, 1951
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Bradenton-Sarasota, 1951
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	Vero Beach, 1951
Florida Specialty Societies			
Academy of General Practice	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	Hollywood, Apr. 22, '51
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	" "
Anesthesiologists, Soc. of	Ralph S. Sappenfield, Miami	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" Apr. 21-22, '51
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" Apr. 22, '51
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 2, '51
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	Ft. Lauderdale, Apr. 21, '51
Dental Society, State	D. Morrison, Sr., D.D.S., Gainesville	Larry Schulstad, D.D.S., Bradenton	Hollywood, Apr. 29-May 2, '51
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	
Hospital Service Corporation	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, June 24-26, '51
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
Public Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Houston, Texas, Dec 4-7, '51
Southern Medical Association	Hamilton W. McKay, Charlotte, N.C.	Mr. C. P. Loran, Birmingham	Dallas, Texas, Nov. 5-8, '51
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	St. Petersburg, April 4-6, '51
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss., October, '51

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					Hon.	Regular	
A	Bay	James M. Nixon, M.D. 825 Jenks Ave. Panama City	Harold E. Wager, M.D. Box 984 Panama City		0	18	A-1-52 Arthur J. Butt, Jr., M.D. Pensacola
	Escambia *Santa Rosa	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	0	73	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	0	6	
	Jackson *Calhoun	Jasper B. Dowling, M.D. Route 1 Mtha	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	0	18	
	Walton-Okaloosa	Arthur G. William, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	0	16	A-2-51 Taylor W. Griffin, M.D. Quincy
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		0	5	
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	0	17	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	2	45	
	Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		0	8	A-2-51 Taylor W. Griffin, M.D. Quincy
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		0	3	
	Taylor *Dicke-Lafayette	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	0	3	212
B	Alachua *Bradford, Gilchrist, Union	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	0	43	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Duval *Clay	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	5	236	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	1	26	
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	1	8	
	Putnam	Claude M. Knight, M.D. 121 Madison St. Palatka	James W. Brantley, M.D. Grandin	2nd Tuesday 6:00 P.M.	0	9	B-4-51 Cleveland D. Cochrane, M.D. Daytona Beach
	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	0	13	
	Brevard	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	0	18	
	Lake *Sumter	H. Darham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	1	23	
	Orange *Osceola	Fred Mathers, M.D. 314 American Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	3	138	
	Seminole	Thomas F. McDaniel, M.D. 315 Magnolia Ave. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	0	13	
	Volusia *Flagler	Peter A. Drohomer, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	2	55	582
C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	0	154	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	0	20	
	Pasco-Hernando- Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	1	12	
	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	9	166	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	1	37	C-6-52 Ieldon W. Martin, M.D. Sebring
	DeSoto-Hardee- Highlands- Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Edwin C. Northup, M.D. Box 98 Avon Park	2nd Tuesday 8:00 P.M.	0	24	
	Lee-Charlotte- Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	0	24	
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	5	80	
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	0	7	D-7-52 Adrian M. Sample, M.D. Fort Pierce
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	St. Lucie- Okeechobee- Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	0	16	
	Broward	M. Austin Lovejoy, M.D. 401 Sweet Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	6	70	D-8-51 S. Marion Salley, M.D. Miami
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

MARCH, 1951

No. 9

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CONVENTION AT HOLLYWOOD

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Recurrent Nonspecific Pericarditis
Walker Stamps

Diagnosis of Cancer
Maxwell M. Sayet

Physician's Place in Community
Charles E. Tribble

American Medical Education Foundation
An Editorial

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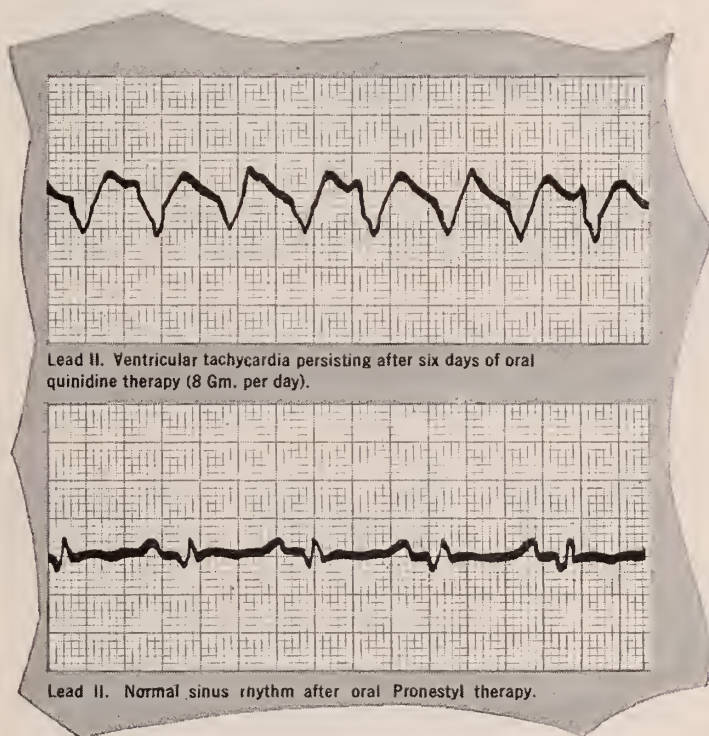
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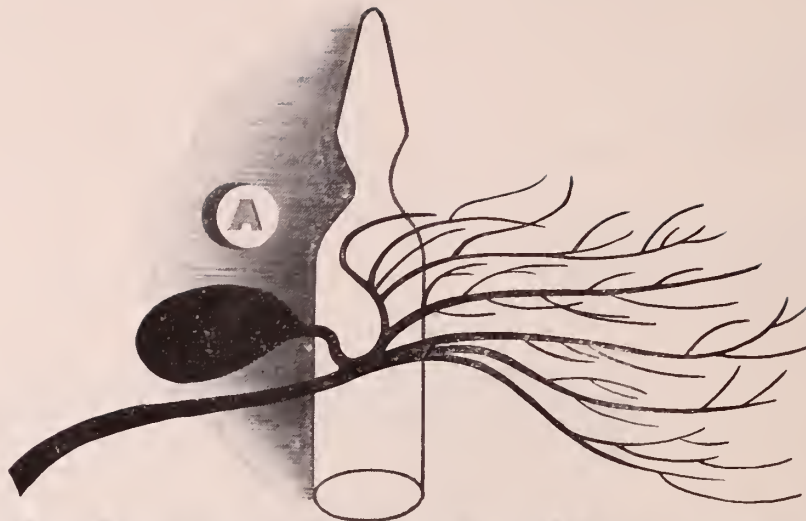
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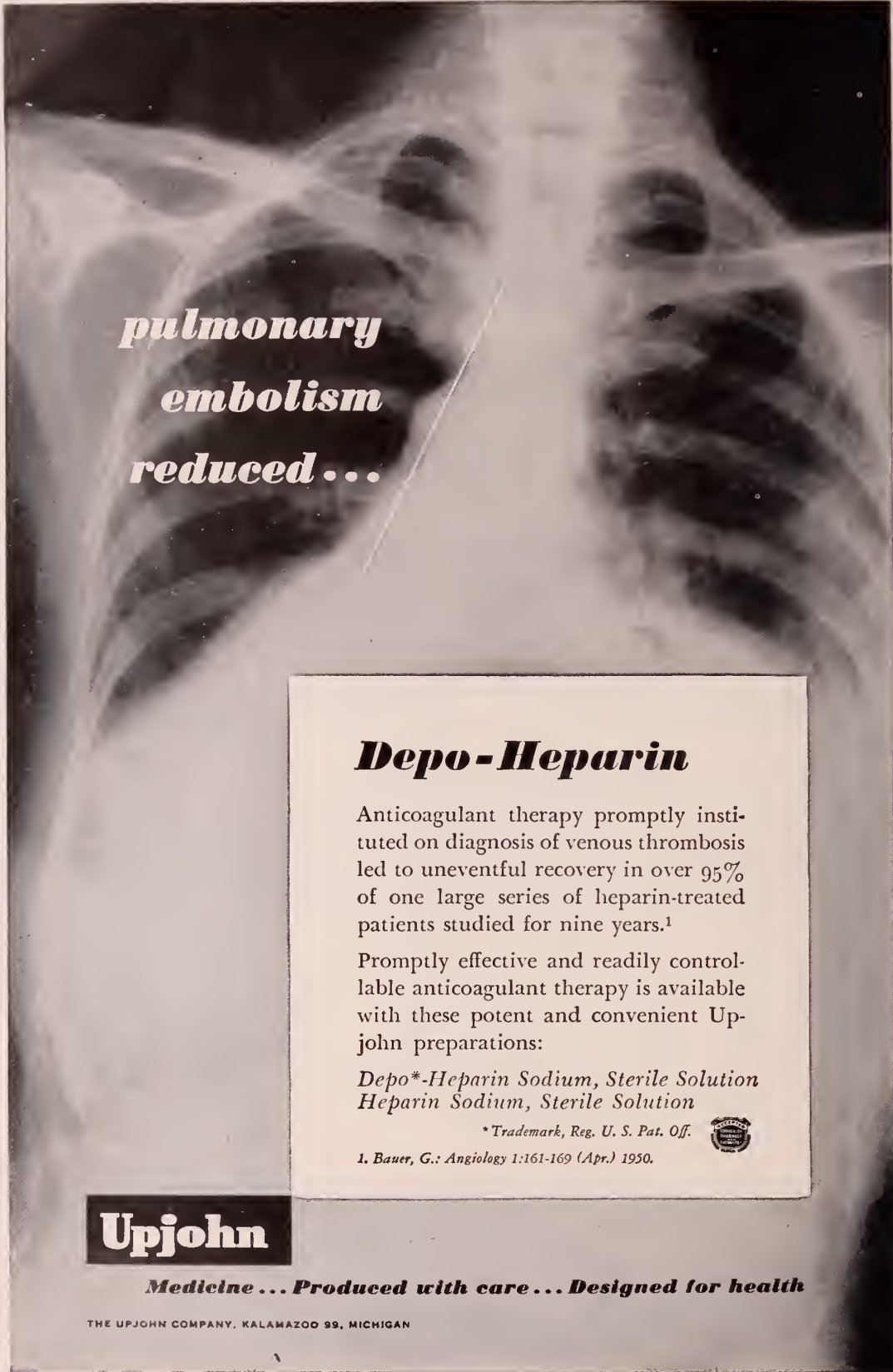
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1. Bauer, G.: *Angiology* 1:161-169 (Apr.) 1950.



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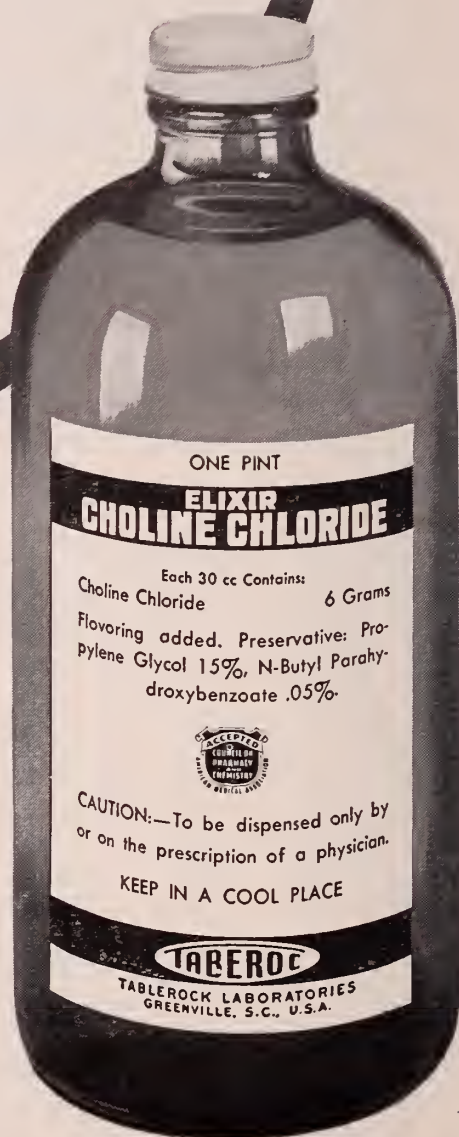
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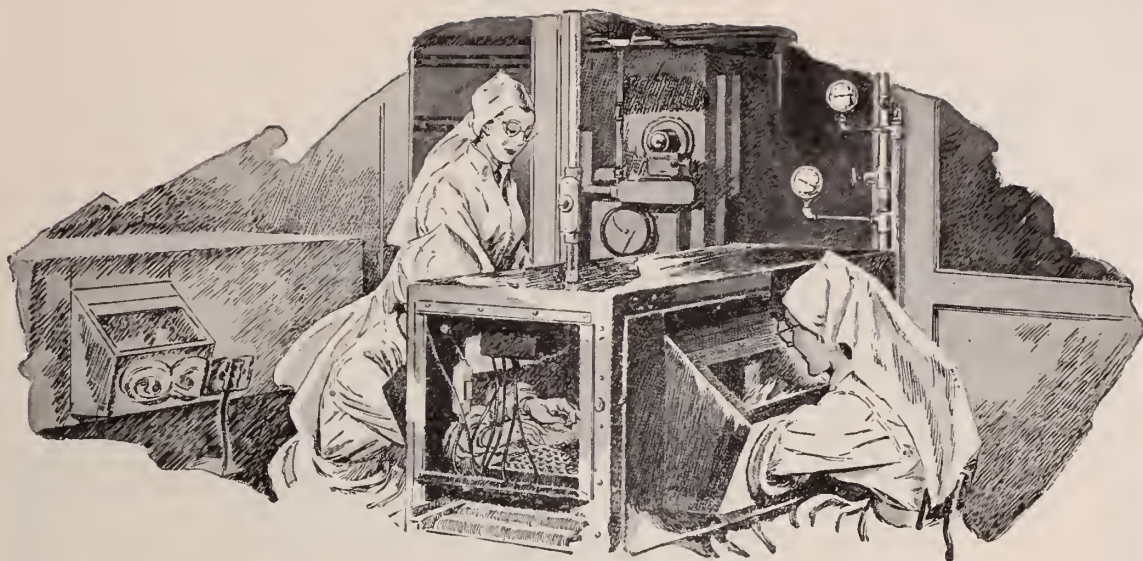
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Hambien, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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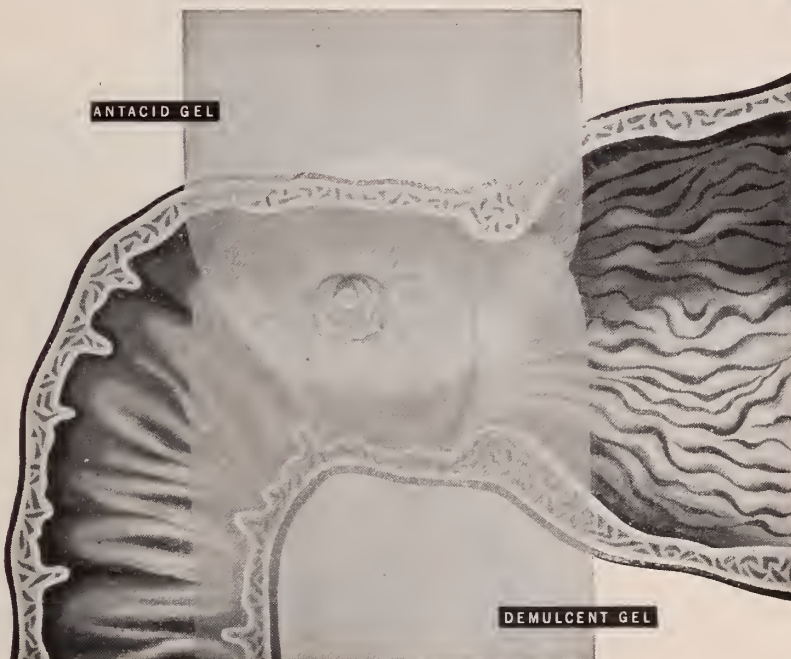
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16	Acute laryngo-tracheal bronchitis	Hemophilus influenzae	3	12	oral	Marked improvement in 24 hours. Recovery

Case report taken from Herrell, W. E.; Heilman, F. R., and Wellman, W. E.: *Ann. New York Acad. Sc.* 53:448 (Sept. 15) 1950.

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Terra

prompt response
in acute follicular tonsillitis

CASE	DIAGNOSIS	CULTURE		DAILY DOSE GM.	NUMBER OF DAYS TREATED	RESULT
		SOURCE	ORGANISM			
29	Acute follicular tonsillitis	throat	Streptococcus pyogenes	4	3	Prompt clinical response. No fever after 24 hours of treatment

Case report taken from Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomev, L. A.: *Proc. Staff Meet., Mayo Clin.* 25:183 (Apr. 12) 1950.

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Knight, J. *New York State J. Med.* 50:2173 (Sept. 15) 1950.

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Dowling, H. C., Lippert, H. H.; Caldwell, E. R., and Spies, H. *The New York Acad. Sc.* 53:433 (Sept.) 1950.

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Schmidt, H. H. *J. Clin. Path. America* 34:1621 (Nov.) 1950.

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(1) Ravdin, I. S., and Gimbel, N. S.: Protein Metabolism in Surgical Patients, J.A.M.A., 144:979 (Nov. 18) 1950.

(2) Vars, H. M., and Gurd, F. N.: Role of Dietary Protein in Experimental Liver Regeneration in Nitrogen Balance Study, Am. J. Physiol., 151:391 (Dec.) 1947.

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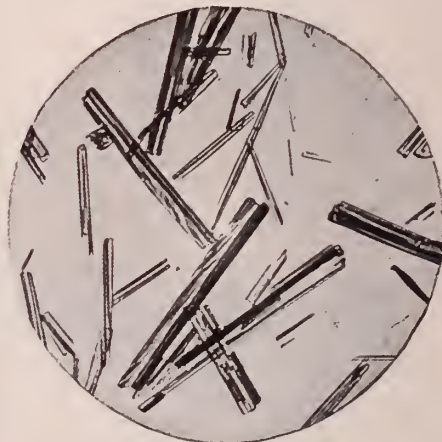
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Recurrent Nonspecific Pericarditis

WALKER STAMPS, M.D.

JACKSONVILLE

Acute pericarditis of benign nonspecific origin has been recognized as a clinical entity for over nine years. Several authors have noted a tendency toward recurrence of the disease.¹ The following 2 cases are thought to present significant evidence for its recurring nature.

Report of Cases

Case 1. — In March of 1939, R. G., a 33 year old white man, had the first of a series of eight severe attacks of pain in the anterior portion of the chest, accompanied by slight fever. The first episode had a duration of forty-eight hours and required morphine injections for relief. The attending physician diagnosed an esophageal spasm. Two years later, in 1941, he again experienced sharp severe pain beneath the lower portion of the sternum. "It hurt so bad I just couldn't breathe," was his comment. In 1943, he had another attack lasting forty-eight hours, again requiring morphine, and twice in 1945. He returned to work in each instance, without any lasting discomfort. Two attacks occurred during 1949, with duration of three and four days respectively, each time requiring hypodermic medication.

His most recent illness occurred June 11, 1950. He applied for relief to the emergency ward of St. Vincent's Hospital. The pain was stabbing substernal without radiation. He "couldn't get one good gulp of air," because of tightness of the chest. He was unable to lie down because of pain and dyspnea. Change of position of the body aggravated the pain. There was profuse sweating. He became weak and fell on an attempted trip to the bath. There was generalized bodily aching.

His past history included an automobile accident six months prior to the first pain in the chest. In this accident, his chest had struck against the steering wheel with sufficient force to bend the wheel about four inches. He had had typhus fever in 1945. There was no rheumatic fever nor history suggestive thereof.

Physical examination showed a well developed, spare white man, 6 feet 4 inches tall and weighing 161 pounds. He was sitting in bed and leaning forward. The temperature was 101 F. The single positive physical finding was a loud, to-and-fro, crunching pericardial friction rub, audible over the lower half of the sternum and along the left sternal border. The heart rate was 86. The blood pressure was 110 systolic and 60 diastolic. A roentgenogram of the chest, taken at 6 feet, showed the heart to be of normal size and shape, with a transverse diameter of 13.8 cm., as compared to a theoretic normal of 12.6 cm. The lungs were clear, and no pleural reaction could be seen. The illustrated second electrocardiogram (fig. 1) showed elevation of the ST segment in leads I and II, and

in V-2, V-3, V-4 and V-5. The hemoglobin estimation was 100 per cent, the red blood cells 5,290,000 and the white blood cells 10,000, of which 52 per cent were polymorphonuclears, 47 per cent lymphocytes and 1 per cent eosinophils. The reaction to the Kahn test was negative. Agglutination tests for typhoid, typhus, tularemia and brucellosis gave negative results. Reaction to a first strength PPD skin test was also negative.

The patient was given 250 m_g. of aureomycin every six hours. The temperature returned to normal within twenty-four hours. He was free from pain in the chest within forty-eight hours and noted only slight substernal soreness remaining. The friction rub was not heard after the first thirty-six hours. He was discharged on the fourth hospital day.

An electrocardiogram taken one month later showed inversion of the T wave in lead I as the only departure from normal. Another, taken some ten weeks later on September 2, showed that T-1 had again become upright. He is at present working hard and is symptom-free.

Case 2. — In 1937, J. W. B., a 50 year old woman, had the first of a series of seven attacks of severe incapacitating pain in the chest, usually of forty-eight to seventy-two hours' duration and accompanied by fever. The pain usually began in the upper interscapular area and extended forward subternally, was aggravated by coughing, sneezing and swallowing. There was no radiation to the arm. She was admitted to St. Vincent's Hospital on Oct. 3, 1947, complaining of severe pain in the anterior part of the chest of forty-eight hours' duration, accompanied by fever to 103 F. There was no evidence of respiratory infection. The heart showed a regular rate of 100. No friction rub was made out. The blood pressure was 96 systolic and 70 diastolic, later rising to 120 systolic and 70 diastolic. The electrocardiogram showed transitory inversion of the T waves in lead 4-F and flattening of the T wave in lead I. Roentgen examination of the chest showed no cardiac enlargement and no pleural reaction. Urinalysis gave negative results. The white blood cell count was 12,200, of which 77 per cent were neutrophils, 8 per cent juvenile forms and 69 per cent segmented forms, 4 per cent eosinophils, 18 per cent lymphocytes and 1 per cent monocytes. The sedimentation rate was 59 and 89 mm. per hour. She was discharged asymptomatic on the fourth hospital day.

In August 1948 she again had a four day episode of pain in the chest and was observed in her home. This time, a loud pericardial friction rub was audible during three days.

On Nov. 26, 1949, there again developed severe pain beneath the lower portion of the sternum, radiating to the back, accompanied by an elevation of temperature to 102 F. Three days later, a pericardial friction rub was heard over the lower part of the sternum. Fluoroscopy showed widening of the cardiac shadow, both to the right and to the left. Roentgenograms of the chest on the eleventh day of this episode showed increase in the size

Read before the staff of St. Vincent's Hospital, Jacksonville, Oct. 9, 1950.

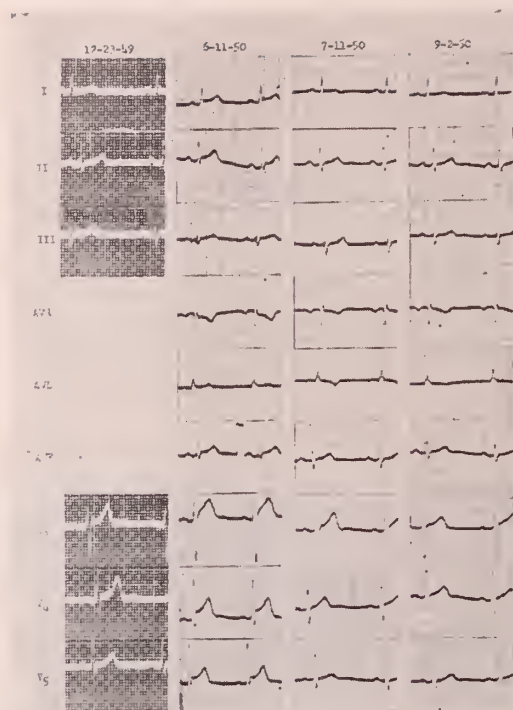


Fig. 1.—Electrocardiograms in case 1, showing a prior normal tracing, then ST segment elevation, T inversion during the attack, and later return to a normal pattern.

of the heart, with retention of the same general cardiac configuration as in 1947 (figs. 2, 3 and 4).

One month later, examination showed neither murmur nor rub. The blood pressure was 130 systolic and 70 diastolic. Venous pressure was 46 mm. of water. Calcium gluconate circulation time was 15 seconds. The heart did not appear to be enlarged on fluoroscopic examination. Pulsations were normal. There was a small amount of fluid in the left pleural space. The electrocardiogram showed T wave inversion in lead I and in leads over the precordium on the left. Conduction time was normal. There were no changes in the tracing taken immediately and five minutes after brisk exercise. The cholesterol determination was 222 mg. per hundred cubic centimeters of blood, the fasting blood sugar 77 mg., and the non-protein nitrogen 25 mg. The white blood cell count was 10,000, with normal differential count. The basal metabolic rate was + 8 per cent.

During her last attack, she was given aureomycin, 250 mg. four times daily, with little alteration in the clinical course as compared with prior attacks. She has remained symptom-free for the past ten months, without limitation of her physical activity.

Discussion

The etiologic agent for nonspecific pericarditis, presumably a virus, has not been demonstrated. Several authors have noted its manifestation following infection of the upper part of the respiratory tract in over 50 per cent of cases,² with a time relation of ten days to two weeks between the nasopharyngitis and the pericarditis. This time interval has suggested allergic responsibility. The diagnosis is made by eliminating other causes of pericarditis—myocardial infarction (table 1),

rheumatic fever, uremia, tuberculosis, septicemia, disseminated lupus erythematosus and pneumonia. In the cases presented, there was nothing to suggest rheumatic fever as an etiologic agent.

Age averages have been reported considerably less than those for myocardial infarction. This difference may be real, or because in young patients one looks for an explanation of severe pain in the chest other than myocardial infarction. If this is an infectious process known to occur in middle age, there is no valid reason to assume unique immunity of the elderly.

The average duration of acute symptoms in the 2 cases presented was about forty-eight hours. This time interval seems to conform to that in most of the reported cases. The patient presents the general malaise and aching common to all febrile disease, a helpful clinical differentiation. In my cases, preceding respiratory infection was not responsible.

The pain is commonly described as a squeezing or clamping. Location of the pain may be epigastric, substernal, precordial, or over the entire anterior portion of the chest. It may radiate to the neck, arm and shoulder, but not to the lower part of the arms and the wrists. The pericardium itself has no nerve supply. The pain, therefore, results from pleural irritation. More rarely, as in case 2, there may be discomfort in the posterior portion of the thorax. The patient usually is more comfortable sitting or leaning forward in a tailor's position. The pain is aggravated by motion of the body—in most instances not exercise, as in

Table 1.—Differential Diagnosis

	Myocardial Infarction	Acute Pericarditis
Friction rub	After 48 hours.	At onset.
Fever	After 24-48 hours.	At onset.
Pain	Aggravated or precipitated by exercise or excitement.	Intensified by body movement, coughing, breathing, swallowing.
Dyspnea	Not usually prominent except in failure.	Present. Failure does not occur.
Malaise, aching	Not present.	Present.
Blood pressure	Falls.	Falls.
EKG	Q waves present. Absent R waves. Reciprocal ST segment changes.	Do not occur. ST segment and T inversion only. Possible, but not usually observed.
X-Ray	Ordinarily no changes in size. Pulmonary congestion.	Dilatation occurs. Pericardial and pleural fluid frequently. No congestion.

angina, but change of position. Coughing, breathing and swallowing may be painful. The dyspnea is of the shallow type because of pain. Its severity may require morphine sedation. With rapid onset of effusion, there may be irritative cough, dysphagia and hoarseness. Tamponade may induce rapid hepatic engorgement and pain. One patient was admitted to St. Vincent's Hospital as an abdominal emergency for this reason.

Cardiac function is not impaired except in the instances of tamponade. Failure does not occur. There is no pathologic condition involved to induce disorders of cardiac rhythm. A slow heart rate is not unusual in pericarditis.³ This has caused speculation concerning inflammatory vagal stimulation.

The diagnostic sign of pericarditis is a friction rub which most frequently is audible along the left sternal border. It may be heard within the first hours of the disease. Contrary to inferential reasoning, the rub may persist throughout the accumulation of large effusions.

Laboratory data concerning the white blood cell count and sedimentation rate are not particularly helpful in either establishing or differentiating the diagnosis. Leukocytosis and elevation of sedimentation rate may be present in pericarditis at the onset. In coronary occlusion, these manifestations are commonly delayed. The leukocytosis is usually of greater duration than in infarction.

The heart actually dilates in acute pericarditis.¹ There is some discussion among authorities as to the part fluid versus dilatation plays in the enlarged cardiac shadow on roentgen examination. It is taught that an effusion of less than 30 cc. is frequently missed by tap and roentgenogram. Pleural involvement is frequently present and radiologically demonstrable.

Electrocardiographic changes of acute pericarditis are due to a current of injury produced by inflammatory damage to the subepicardial layer of myocardium. There are four patterns of change which involve elevation of the ST segment and inversion of the T wave in a single lead or a combination of leads. These are lead I, leads I and

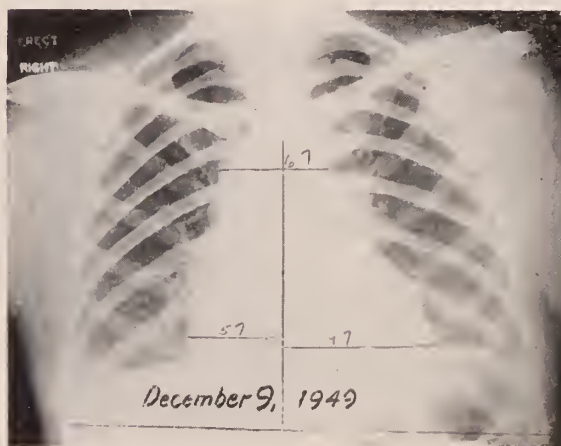


Fig. 3.—General enlargement of the cardiac silhouette following an acute attack. There is some exaggeration of the change because of elevation of the diaphragm.

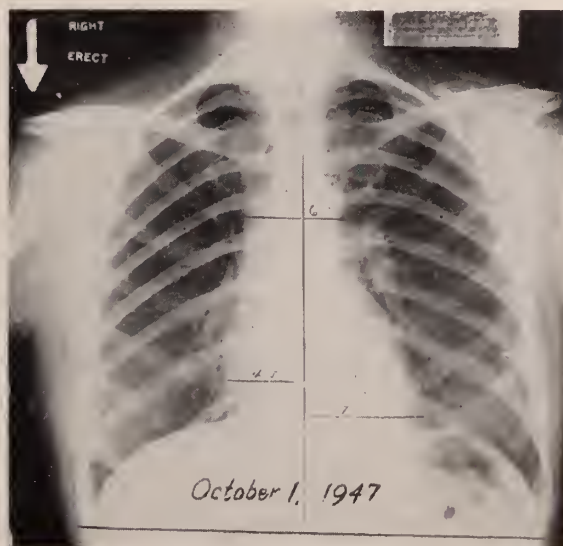


Fig. 2.—Normal heart size in October 1947 in case 2.

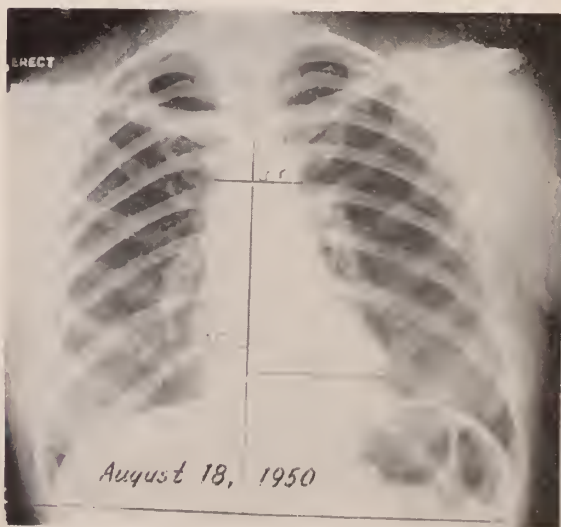


Fig. 4.—The heart size is normal in August 1950.

II, leads I and V-4, and leads II and V-4. The ST segment in lead III is typically unaffected. There are ordinarily no reciprocal changes as in myocardial infarction because the pericarditis is usually a diffuse process involving the heart's entire surface. Pericarditis in localized areas could produce reciprocal deviation in the ST segments of leads I and III, just as in infarction, but no clearly documented reports were found. There are no significant changes in the QRS pattern. No Q waves develop, and the R wave does not disappear in the chest leads. The ascending limb of the T waves is straight or concave upward. The T wave may be dome-shaped. If serial tracings are made, the diagnosis may be indicated by this laboratory test alone. The T wave inversion may vary rapidly from day to day and is seemingly unrelated to the clinical course of the patient. The electrocardiogram reverts to normal within a usual maximum time of eight weeks. Cardiac tamponade by hemorrhage is the only pathologic state which will produce identical patterns in the electrocardiogram. The traumatic history readily eliminates this possibility.⁵

As for therapy, each new antibiotic has been used successively to treat the disease. Aureomycin in daily 2 Gm. dosage was used in both cases reported here. The duration of the acute process was no shorter than on former occasions. It may be that longer treatment would eradicate the causative agent.

Summary

Nonspecific pericarditis may present itself in a recurrent manner. It is apparent from the 2 cases with repeated acute pericarditis here presented that there is in this disease no cause for chronic constrictive pericarditis. The prognosis is uniformly favorable, and no demonstrable ill effect need result.

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A Physician's Place in His Community

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DELAND

All of us who are practicing medicine today have heard of that wonderful character so often referred to in nostalgic terms, the character who has become legendary in his wonders—the old time family doctor. This worthy and much loved gentleman was a horse and buggy doctor. When civilization moved on horseback, or by cart, wagon, or buggy, it necessarily moved slowly. In those days a doctor had time to meditate, time to think, time to visit, and time to live. When he was called two miles out of town to make a call, it took him all morning to make that one call. It took him a long time to make any call. It also took the patient's family a considerable time to get word to the doctor that he was needed. The obstacles inherent in calling the doctor forced people to think four or five times before they sent for him. The family tried many remedies before at last resorting to a physician. These have come down to us in a

crazy pattern of superstition, but medicine in those days was hardly much better. At any rate, there was some resourcefulness in the family.

Things are different today, for we have telephones, paved roads and fast-traveling automobiles to make doctors readily available; and we have radios, newspapers and magazines to tell people of the constant dangers that lurk in the shadows of their doubts, to tell them of miraculous remedies if they will but call the doctor in time. All of you have felt the impact of these changes. You have spent days seeing people in astounding numbers in your offices, people who for the most part were worried sick by the terrific weight of fear that cancer, tuberculosis and syphilis drives, that health and sickness magazine articles, have produced. Then you have spent the evening with deliveries, emergency surgery, automobile accidents, miscarriages, heart attacks, asthma or any other of the legitimate emergencies, and have come home dead

⁵Read before the Marion County Medical Society, Ocala, Sept. 19, 1950.

tired, shucked off your clothes and dropped in bed, only to curse at the ringing of the telephone. Some mother has been aroused by Junior's cries. When she felt him he had a fever, and she immediately asked, "Honey, does your head ache?" Honey whimpered and said "Unghhungh." Mother became worried and asked, "Is your neck stiff?" Junior tried his neck and said it was. Mother then became frantic and called you, saying "Come out right away. I know Junior has polio." That experience would be funny if it were only an occasional one, but it happens entirely too frequently to have humor in it. That just about epitomizes the plight of the present day general practitioner. In comparison to the love and esteem in which his granddaddy was held, he is a heartless, cranky old fool.

Today, there is no time to read; we watch our periodical file pile up, our books grow dusty. There is no time to think except in flashes. There is no time to visit and speak upon the trends in our city, county or state government. What then can be our place in a modern community? It is necessarily in the nature of a minor role; and yet we have had more and better education than the average good citizen, we have come under the inspiring influence during our early years of some great men, and all of us have visions of better things.

Were I asked what, in my opinion, are the most glaring weaknesses in our present day civilization, I would say: a lack of true vision, a dearth of ideals, a cynicism in regard to good things, an appalling failure to feel a sense of responsibility, an impalpable, vague, elusive fear of an impending disaster, either in private lives, in economic matters, or public affairs, and entirely too much liquor-drinking. These weaknesses for the most part are the apothegms that settle out in unreasoning, unenlightened living. The doctor who is best qualified by education and experience to understand these matters of human behavior is too busy to pause and give a helping hand. And please do not think that matters of human behavior are not reflected in all of our political and governmental subdivisions.

Now I have established the fact that doctors are too busy to take part in their community life, but when I mentioned some of the weaknesses, I mentioned a lack of a true sense of responsibility. By the nature of our education, training and experience we owe a responsibility to our communities, the responsibility of making ourselves heard and felt. The recent narrow escape this country

had from having a system of socialized medicine crammed down its throat is a point to illustrate how derelict we have been in the matter of our politics, and our government and public relations. I do not suppose you would be surprised to know that in the simple matter of voting we have the astounding record of about 20 per cent. One out of five of us votes. And yet the power of the medical profession if exercised, could be tremendous. We are trained to think logically, to reason from solid premises to clear conclusions. Why cannot we pause in our hurry to speak logically to those who follow the reasoning of others? It is sometimes surprising to note the ease with which most people will follow a reasonable argument, for reasoning powers are common. The trouble with most people is that they do not have a sound enough basis of knowledge upon which to reason. If the knowledge can be supplied, they will follow the reasoning. And here lies the first responsibility of educated men.

Knowledge to those unaccustomed to knowledge can be confusing, for critical judgment is lacking. To weigh one apparent fact against another apparent fact is difficult for the best minds, and terrifically confusing to the lesser. Here again the mind trained in critique can make itself felt in a beneficent manner.

Of all the professions practicing today, there is only one that is giving much of its time and energies to questions of vital and public interest, and that is the legal profession; this activity is understandable since this profession is the child of government. But that does not mean that the legal profession is the only profession competent to pass upon these matters, not by any means. I firmly believe all of the various political and governmental subdivisions need the benefit of the peculiar outlook and manner of thinking of the medical profession. Government today is losing the most precious possession a man has, and I refer to the dignity of personal liberty. In all of the classical concepts of government voiced by our early political philosophers the dignity of the individual was stressed. Today, in the gigantic mill that turns out laws and regulations for the 150,000,000 people, there is no time or place for the consideration of the individual.

When the individual loses his identity, he loses his soul, and that which the Christian world has been building up to for two thousand years is lost. Who is in a better position to appreciate and understand the individual than the man whose pro-

fession it is to work upon him? Who should be more conscious of the rights and the dignity of the individual than the doctor? But we are too busy attending the fears and apprehensions of a remarkably healthy race of people to pause and give thought to the direction in which we are traveling. Unless there is a radical change instituted soon, we are drifting into a statism that will be the death of all personal liberty, and we, as individuals, will become numbers only and be classified in impersonal blocks, of which the medical profession will be just one block.

Let us forget our socialistic trends, let us forget our responsibility as citizens, let us forget that in education there is an inherent obligation, and let us be selfish for a moment. Have you gentlemen given any thought to the income tax laws and regulations? Have you stopped to consider that the setup as it exists today is designed to make it well nigh impossible for a professional man to lay up even enough upon which to retire in his feeble years. As the income tax laws now exist, all that a man can hope to save is taken by Uncle Sam. Start at the bottom and work up. The more a man makes the higher plane upon which he lives, and the greater is the margin between his living expenses and his income, but with uncanny insight Uncle Sam has figured that margin to be his, no matter at what level one earns.

The salaried worker, the job holder, the government employee, the teacher, even the plumber's helper, for the most part have some type of retirement pay, social security or otherwise, when the age arrives. In many instances only a part, or even none, is contributed by the employee. But what does the professional man or small independent businessman get? He gets the privilege of paying out all of his savings so that he may eventually come to a destitute old age. He may have a retirement insurance policy and then what happens? Out of the little bit he has been able to scrimp and save he has paid his premiums. Then when he starts drawing his retirement check he pays income tax for the second time on his own money. Of course, the professional man is not alone in this double taxation sleight of hand. All retirement incomes, unless they are too small to matter, must help to finance Uncle Sam's give-away programs. It's just a bit tougher on the professional man who was the sole contributor to his little nest egg in the first place. Economically, the professional man is fighting a losing battle. He is a dead duck.

Now why is this? My guess is it lies in the noble disdain we have for the duties and responsibilities of citizenship. One out of five of us votes, we never make ourselves felt as vote swayers; consequently, we are not looked upon as worthy of consideration by the minds that fabricate these laws and regulations. Nor do we have a legitimate protest, for we have forfeited our right to protest. When we are too busy, too good, too pure for politics, then we must accept the abuse to which we are subjected with sportsmanlike grace.

Since we are driven to desperation by a loud public demand for constant medical attention twenty-four hours around the clock, since we do not have even the time necessary for our own personal problems and personal living, what then are we to do? As Patrick Henry said, "I cannot answer for others." In my own particular case, I ran for mayor, and I cannot remember when I have had so much fun. It was a great diversion. Since assuming office, however, the fun has left me. It is now just that much more work. Needless to say I have had to sacrifice some of my practice, but with the income taxes what they are, where is the commercial incentive to work hard? I am not so constituted that I get pleasure out of earning money for Uncle Sam to take. And then we have two young men in our town who are just beginning to build their practice, and they need a break. So I give so much time each week to supervising the operation of our town, and I enjoy doing so.

A city is a business. It is the business of getting all those things that individually the people cannot get for themselves, and that is all that a city is supposed to be. Running that business is a grave responsibility, but it also can be a happy one.

What do I get out of being a mayor? As far as I personally am concerned, there is only one important remuneration. I get some political consideration. I have some votes which I can and I intend to influence. In that there is enough power to make my voice heard, there are a few things I am going to speak about. The ears of our various political and governmental subdivisions are attuned to vote strength and vote strength alone. That is the only realistic attitude to take. To accept that and use it, not for personal gain, but for public good, is a challenge to our basic ideals.

Gentlemen, I hope I have not succeeded in thoroughly confusing you, but instead have succeeded in germinating a thought.

A Case of Tetralogy of Fallot with Both Coronary Arteries Arising from the Pulmonary Artery

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The authors were unable to find a case in the literature similar to the one reported. Two cases were reported with both coronary arteries originating from the pulmonary artery, 1 by Lumbourg¹ and 1 by Grayzel and Tennant,² the former with no other cardiac anomalies and the latter with multiple anomalies. Origin of one coronary artery from the pulmonary artery, on the other hand, frequently was reported.

Report of Case

HISTORY.—The patient was born normally on the Obstetrical Service of the Morrell Memorial Hospital, Jan. 29, 1950. The child was a white girl, normal in appearance and development, weighing 9 3/4 pounds and 21 inches long. The day following delivery it was noted that breathing was rapid; the skin was slate-colored and appeared somewhat dehydrated. The fingers were cyanotic, and a systolic murmur was present over the apex. The condition became worse, and the infant died on the fourth day of life. A roentgenogram taken on the second day of life was interpreted as indicating cardiac enlargement possibly due to a septal defect and atelectasis of the right upper lobe of the lung. In the erect posture at 72 inches the transverse shadow was 9.5 cm. and the cardiac shadow 7 cm. The hemogram on the fourth day showed 20,800 white cells and normal red cell and differential counts. The urine showed 2 plus albumin.

NECROPSY FINDINGS.—With the exception of atelectasis present especially in the upper lobes of both lungs and congestion of various organs, significant findings were limited to the heart. The heart extended across the thoracic cavity, occupying approximately two thirds of the cage. Ten milliliters of clear amber fluid was present in the pericardial cavity. The heart weighed 36 Gm. The shape of the heart suggested a wooden shoe with the concavity in the region of the pulmonary conus. The valves of the aorta were normal, but there were no coronary ostia. The foramen ovale and ductus arteriosus were patent and showed no abnormality. The width of the left ventricle averaged 7 mm. and of the right 4 mm. The aortic valve measured 3 cm., the mitral 3 1/2 cm., the pulmonary 1 cm., and the tricuspid 3 cm. The ventricles appeared hypertrophied, and the right auricle was markedly dilated. The aorta was in dextroposition, and there was an upper ventricular septal defect of 1 cm. (fig. 1).

The narrow pulmonary artery and two coronary ostia are shown in figure 2. These ostia are continuous with the right and left coronary arteries, which pursue a normal course. Strands of tissue about 2 mm. in length in

a position coronary arteries would normally occupy extend from the patent coronary arteries to the aortic valve forming a small Y.

Discussion

The basic factors in defective development of the heart often are not clear. Practically all structures of the heart may be involved singly or in combination. Anomalies may be divided clinically into those incompatible with intrauterine life, those compatible with fetal life but not extrauterine life, and those compatible for varying periods of time with extrauterine life. Our case fits into the second category.



Fig. 1. Septal defect and aortic valve. When flaps are depressed, no coronary ostia are present.



Fig. 2. Pulmonary valve. The two coronary ostia are visible. The one on the right was torn slightly by probing. The relative size of the aorta and the pulmonary artery is apparent. See figure 1.

Grayzel and Tennant² suggested two theories to explain the anomalous origin of the coronary arteries in the pulmonary artery.

1. Coronary artery anlage arises in the wrong location in the wall of the aortic bulb so that the normally forming septum includes the coronary artery within the pulmonary artery, instead of the aorta.
2. The coronary artery anlage is normally disposed, but the bulbar septum forms in the wrong place and incorporates one or both coronary arteries within the pulmonary artery.

Another theory is suggested by this case since two strands lead to the aorta from the right and left coronary arteries. Normally the coronary arteries occupy the positions of the strands. If one assumes that somewhere in the stage of development the aorta and pulmonary valves are mirror images one of the other, the coronary arteries would lead to both. Normally the vessels to the pulmonary artery would be absorbed or remain only as strands leaving the coronary arteries to the aortic valve. On rare occasions such as this, however, the reverse is possible.

Conclusion

A case of tetralogy of Fallot with the coronary arteries arising in the pulmonary artery is reported. A theory based on mirror image development of the aorta and pulmonary artery is suggested with in this instance the coronary arteries to the pulmonary artery remaining open and those to the aorta persisting only as fibrous strands. This is contrary to normal sequence and may have been provoked by the existence of another anomaly, namely the tetralogy of Fallot.

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P. O. Drawer 873.

Seventy-Seventh Annual Convention

Florida Medical Association

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Cytologic Diagnosis of Cancer: Method of Papanicolaou

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The examination and recognition of cancer by the study of desquamating cells is not new. Ascitic and pleural fluids have been examined by pathologists for such cells for many years. Papanicolaou in 1928 in association with Trout demonstrated carcinoma cells in vaginal smears. This accomplishment was an outgrowth of the former's studies of the endocrine changes occurring in the vaginal epithelium. Gates and Warren in Massachusetts and Meigs in New England have continued the study and have accumulated a mass of statistical material.

The pathologist has been reluctant to use this method because it appeared unlikely that single cells would be adequate for diagnosis of cancer. Numerous difficulties are encountered even when segments of tissue are available. This objection, however, is partially negated in that in some cases visible or accessible carcinoma is not present, or repeated biopsies are not feasible. The study of repeated smears may be fruitful of diagnosis.

The method is still in a state of development. The accumulation of additional material and the devising of new methods of staining may help this method in accuracy and practicability.

Obscure and early cases of carcinoma have been unearthed by this method, a fact which is one of its most promising recommendations. If this method is to be made to work, there is a need for selection of cases, competent examination, an evaluation of diagnosis and a repetition of smears.

Technic

An adequate history, including the age of the patient, the last menstrual period, the symptoms, any operative procedures, and the use of roentgen rays or endocrines, is an essential part of this procedure since the evaluation of the cells in the smear is dependent to some degree on these facts. For example, the finding of endometrial type cells in a patient in the menopause will excite the suspicion of adenocarcinoma of the fundus.

From the Department of Pathology, Mount Sinai Hospital, Miami Beach.

VAGINA.—Three types of vaginal smear are recommended. First is the simple smear obtained by inserting a piece of glass tubing into the posterior fornix and aspirating a small quantity of material. This is immediately streaked on a glass slide, which is then dropped into the preservative (equal parts of ether and 95 per cent alcohol). The smear must be dropped into the alcohol-ether solution before drying begins, as swelling of the epithelial cells occurs in the latter contingency, interfering materially with the microscopic examination. This is probably the best general procedure inasmuch as the pooling of desquamatory cells from the uterus, cervix and vagina occurs here.

The endocervical aspiration is done by means of a laryngeal cannula. A small quantity of endocervical mucus is aspirated and handled as the vaginal secretion.

The third type of smear is made by scraping suspicious areas of the cervix with a tongue depressor or curette. In the latter two types of smear drying is rapid, and the speedy placing of smears into the fixative is important. Each of these smears must be labeled as to origin, since the presence of certain deeper cells (parabasal) will be expected in one smear and not in the other. Vaginal smears should be prepared before pelvic examination or use of any lubricant. Prior douching or bathing should be avoided.

RESPIRATORY TRACT.—Sputum obtained from deep cough is put directly by patient into a glass sputum jar containing 70 per cent alcohol. If no bronchial secretion is obtainable, the bronchus is irrigated with 10 to 15 cc. of saline and the irrigation fluid mixed with 95 per cent alcohol. Recovery of cancer cells from one bronchus does not of necessity indicate the location of the tumor. There is a tendency for admixture of the sputum.

URINARY TRACT.—The urine of female patients is catheterized. In male patients catheterization is not necessary but preferable. When a lesion is suspected in the kidney or ureter, ureteral

specimens are desirable. Each must be properly labeled as to right or left side. Each specimen is mixed with an equal amount of 95 per cent ethyl alcohol immediately. Usually, 50 cc. of urine is required. Excellent results with tumors of the bladder have been obtained.

GASTRIC SPECIMENS.—The patient must have had nothing by mouth for eight hours previously when a gastric specimen is obtained. It is preferable to use the Rehfuß tube with a bucket tip. The total contents of the stomach are aspirated, collected in a glass container, and immediately mixed with an equal amount of 95 per cent alcohol. It is necessary that the laboratory receive this specimen immediately. There is extremely rapid digestion of the cellular elements. Keeping the specimen refrigerated may delay this somewhat. Results are not good. There is little tendency for the pooling of cells.

COLONIC WASHINGS.—When colonic washings are desired, a cathartic at night and an enema the next morning are given. Two to three hours later, never immediately after, saline washings are obtained and approximately 100 cc. mixed immediately with an equal amount of 95 per cent alcohol (ethyl, isopropyl, or methyl).

FLUIDS.—Pleural, peritoneal, pericardial or any other type of fluid is mixed with an equal part of 95 per cent alcohol. Usually, 50 cc. is an adequate amount.

Sources of Error

Error may arise from several sources: (1) In general, great experience and time are required, and are not as a rule available. (2) The collection of the specimen may be faulty, for many times orderlies are relied upon to obtain it. (3) The staining technics may be faulty.

FALSE POSITIVES.—False positives arise as a result of chronic inflammation of the cervix with the presence of large numbers of histiocytes and parabasal cells.

Squamous metaplasia may give considerable trouble because of the difficulty in some cases of differentiating this condition even with tissue sections.

Radiation produces swelling of the epithelial cells which occasionally makes one suspicious of cancer.

FALSE NEGATIVES.—Due to the fact that some carcinomas do not have anaplastic-appearing cells, their shedding excites no suspicion of cancer. A typical case would be adenoma malignum of the

uterus. Some carcinomas desquamate so sparsely that a diagnosis of carcinoma is not likely. Here, the repetition of smears is especially important.

Statistics

The statistics of the vaginal method have been rather carefully worked out. At present there is a good deal of variation by the workers in the field, as to the per cent of error. Generally speaking, it varies from 0.3 per cent to 4 per cent depending upon the place the material has been accumulated.

Statistics on the urinary, gastrointestinal and respiratory tracts have not been worked out on large numbers of cases as yet. At present, approximately 10 per cent of the smears are in error with many more false negatives than false positives. The technics are as yet uncertain, and the differential cytology is not well known. It is believed that, with further work, results comparable to those of the vaginal method may be available.

Recommended Use

This method is not a substitute for other procedures, rather a corollary. This important attitude must be fully appreciated before one should consider using this procedure. Appropriate uses include: (1) A symptomatic case with negative physical findings of the genital tract would be one type of case in which its use should be recommended. (2) Similarly, in symptomatic cases with suspicious physical findings in which biopsy and curettage are not justifiable this method should be useful. (3) In suspected carcinoma with negative results from biopsy and curettage a hidden carcinoma might be revealed. (4) Its use in prophylaxis in asymptomatic cases has been widely publicized. This procedure will uncover approximately 3 cases of carcinoma per 1,000 examinations of women in the cancer age. (5) This method has proved of great value in following

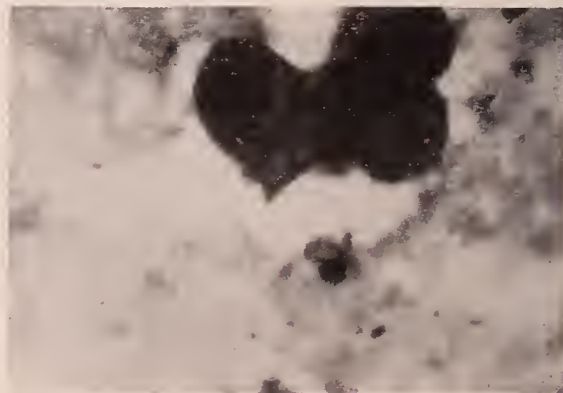


Fig. 1.—Sputum containing cancer cells—bronchiogenic carcinoma.



Fig. 2.—Pleural fluid in a case of adenocarcinoma of the lung.

borderline cases. Weekly, monthly, or trimonthly examinations are made, and the so-called precancerous lesion can be observed successfully without resorting to so frequent biopsy or curettement. (6) This procedure has been used to determine the success of treatment. Following radium therapy it is feasible to continue repeated examinations of the vaginal fluid to watch for recurrence. Finally, (7) this method may be used as an adjunct to biopsy because it can be repeated frequently without upsetting the patient.

The Method of Reporting

Dr. Papanicolaou divides the smears into five classes; Class 1, negative; Class 2, atypical cells, no malignant disease; Class 3, suspicious (approximately 50 per cent turn out positive); Class 4, fairly conclusive evidence of carcinoma; Class 5, conclusive evidence of carcinoma and responsibility for major operation.

Characteristics of the Malignant Cell

There is a pathognomonic malignant cell which, in essence, is the cell that determines the degree of malignancy in tissue sections. It is an atypical cell. Its size is usually large, but not necessarily so, depending on the type of the tumor. The nucleus is the outstanding feature (activated). It is as a rule darker than normal (hyperchromatic); it is irregular in shape; its size is greater than anticipated for the cell containing it; and the nucleoli are larger than normal and may be more numerous. The chromatin content is usually irregularly deposited. This cell is better seen than described (figs. 1 and 2). It must be understood, however, that not in every case is the pathognomonic malignant cell deposited, for cancers vary as to anaplasia.

420 Lincoln Road.

ABSTRACTS OF MEDICAL ARTICLES

ACUTE NONSPECIFIC BENIGN PERICARDITIS. By Elwyn Evans, M.D. J. A. M. A. 143:954-957 (July 15) 1950.

Dr. Evans reports a series of 11 cases (with 4 added later) of acute benign nonspecific pericarditis encountered in private practice in a subtropical climate, 8 of them during one year. Pain in the chest aggravated by body motion or deep inspiration was the predominant complaint. In 10 cases a pericardial friction rub was heard early, and in 10 electrocardiographic changes indicative of pericarditis were present. Differentiation of pericarditis from acute coronary occlusion is emphasized, as is differentiation of rheumatic carditis and pericarditis.

A case of possible contact transmission is described. The author notes that pericardiocentesis is not indicated unless there is evidence of serious cardiac tamponade. He regards acute nonspecific pericarditis as more common and more widespread than is generally realized.

PAROXYSMAL NODAL TACHYCARDIA WITH ABERRANT VENTRICULAR PATTERN. By N. Stuart Gilbert, M.D. Am. Pract. 1:279-285 (March) 1950.

A case is reported in which paroxysmal nodal tachycardia with aberrant ventricular pattern, an arrhythmia rarely encountered and characterized by its persistence and obstinate resistance to therapy, was effectively controlled by combined use of digitalis and neostigmine methylsulfate. Associated with the tachycardia were many attacks of cardiac failure, eventual cardiac enlargement, and abnormal electrocardiographic tracings with suggestive myocardial infarction patterns.

The author advised continued electrocardiographic and clinical observation of patients in the post-tachycardial state for a period of several months in order to determine the exact amount of cardiac damage resulting from these episodes. He observed that by controlling the tachycardia these damages were shown to be reversible.

Hollywood Again This Year

The Convention City

As April approaches, that "dream city come true," Hollywood-by-the-Sea, beckons to the members of the Florida Medical Association to gather there once more for the annual convention. This famed resort on the tropical east coast of Florida only thirteen miles above Miami Beach has long been a popular convention city, especially with the Association.

Incorporated only a quarter of a century ago, this city of friendly people and beautiful homes has enjoyed phenomenal growth, now boasting a year round population approximating 15,000. Its six miles of municipally owned beach, two golf courses and many recreational facilities, together with its excellent climate, attract thousands of winter visitors annually. It well deserves the important place it has won for itself in the Greater Miami area.

The Hollywood Beach Hotel, where the meeting will be held, may aptly be described as a city within a city. As many members know, it is completely self sustaining, providing every type of facility and service required for guest comfort as well as for convention meetings. The popularity of this Florida ocean front hotel with the Association is attested by the frequency with which it has met there. The first meeting in this delightful setting took place in 1933. On short notice in an emergency situation in 1942 the hotel proved a gracious host for the second time. Only last year the Association met there for the third time and is happy to return again this year.

In addition to every provision for a successful convention, the hotel offers exceptional entertainment and recreational facilities, including its private bathing beach, new Olympic size swimming pool, tennis courts and nearby golf course. There is even deep sea fishing but a few rods distant. Also, diversified entertainment for the ladies is always available.

The attractions of the Hollywood Beach Hotel, the city of Hollywood and the entire resort area of which they are a part invite a large attendance at the seventy-seventh annual convention and assure diversion and recreation. Along with the outstanding scientific program, the constructive business sessions and the excellent technical exhibits, they should contribute notably to the success of the meeting.



Hollywood Beach Hotel—Convention Headquarters for 1951

PROGRAM

of the

Seventy-Seventh Annual Meeting

FLORIDA MEDICAL ASSOCIATION

To be Held at HOLLYWOOD

APRIL 23, 24 and 25, 1951

REGISTRATION

East End of Exhibit Hall

The Registration Desk will be located at the East end of the Exhibit Hall and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 1:00 p.m. Every member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the above designated Registration Desk and obtain their badges.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay \$3.00 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Cabañas and Pool at 9:00 p.m. Monday and worn throughout the evening.

CONVENTION HEADQUARTERS

HOLLYWOOD BEACH HOTEL

The general headquarters will be the Hollywood Beach Hotel, where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical exhibit hall will be located.

The Hollywood Beach Hotel will be headquarters Saturday and Sunday for the 18 specialty groups approved by the Board of Governors.

GOLF

The annual handicap golf tournament for members of the Florida Medical Association will be played at the Hollywood Beach Hotel Links. The tournament will be held Sunday, Monday and Tuesday, April 22, 23 and 24. There will be no Green Fees for members registered at the Hollywood Beach Hotel. Those registered elsewhere will be charged \$1.00 per day. Transportation and lockers will be on a free basis.

Those wishing to participate must be registered and show F. M. A. badges.

Rules: U. S. Golf Association, except local rules.

Handicaps: The local professional will handicap the players. The entrant must register with the starter before beginning his tournament round.

Score card must be dated, signed, attested and turned in to the starter at the end of the round.

Voucher for prizes will be awarded at the Association dinner. First prize: Orlando Loving Cup (low net score). Many other attractive prizes will be awarded. (*The last winner of the Orlando Loving Cup, Dr. William G. Meriwether of Plant City, is requested to deliver the cup to Dr. Lloyd U. Lumpkin, chairman of the golf committee, on his arrival at the convention.*)

For additional information contact Dr. Lloyd U. Lumpkin, 918 E. Las Olas Boulevard, Ft. Lauderdale.

ANGLERS

Deep sea fishing trips will be available. Boats leave from the City Pier. Arrangements may be made for all day or short trips at nominal charges.

Reservations should be made well in advance if possible. Communicate with Dr. Benjamin F. Hart, 1627 S. Andrews Avenue, Ft. Lauderdale.

TRAPSHOOTERS

Members interested in trapshooting are requested to communicate with Dr. S. Elliott Wilson, Chairman of the Trapshooting Committee, 380 S. E. 2nd St., Ft. Lauderdale.

The shoot will consist of 50 targets trap and 50 targets skeet and prizes will be awarded for each. The shoot will be held at the Broward Gun Club, Naval Air Station, Ft. Lauderdale.

SMOKER (*Not Stag*)

Monday, 9:00 p.m.

HOLLYWOOD BEACH HOTEL — CABANAS AND POOL

Hear ye! Hear ye! The Carnival is open tonight. Games and prizes, food, drink, dancing. The greatest show on earth. Step right up, ladies and gentlemen. Arrangements have been made by the Smoker Committee, of which Dr. Russell B. Carson is chairman.

Smoker privileges will be \$3.00. You can't beat it. Get your tag before 5:30 p.m. at the Registration Desk in the Exhibit Hall. Come one — come all.

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

HOLLYWOOD BEACH HOTEL — MAIN DINING ROOM

Those who are not lodging at the headquarters hotel may obtain dinner tickets (\$5.75 per person) from the hotel cashier.

HOTELS**HOLLYWOOD BEACH—HOTEL HEADQUARTERS***(American Plan)*

Single \$14.00 Double \$28.00

American Plan rates at the Hollywood Beach Hotel include meals, which are priced as follows:

Breakfast	\$1.75
Luncheon	3.50
Dinner	5.75

Persons not lodging at the headquarters hotel may be served meals in the Main Dining Room at the prices quoted. Individual meal tickets sold at cashier's window will include 10% to cover gratuities for those who do not have rooms in the Headquarters Hotel.

For your convenience we have arranged with the hotel management that there shall be no tipping at any meal. A charge of \$1.00 per day will be posted to your hotel account to provide gratuities for dining room employees.

OTHER HOTEL ROOMS**SHELDON**

(100 Boardwalk)

Single Rooms	\$ 4.00
Double Rooms	\$ 5.00

GREAT SOUTHERN
(Hollywood Blvd.)

Single Rooms	\$ 3.50- 5.00
Double Rooms	\$ 7.00- 8.00

HUTCHINSON
(404 N. 17th Ave.)

Double Rooms	\$ 4.00
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JOHNSON HOUSE
(998 S. Federal)

Single Rooms	\$ 4.00- 5.00
Double Rooms	\$ 5.00- 6.00
Apartments	(per day) \$ 8.00-12.00

SEASIDE MANOR
(Ocean Dr.—Mich. St.)

Single Rooms	\$ 5.00
Double Rooms	\$ 6.00

WINDSOR
(322 Buchanan St.)

Single Rooms	\$ 4.00
Double Rooms	\$ 6.00

ROYAL PALM
(1957 Jackson St.)

Single Rooms	\$ 4.00
Double Rooms	\$ 5.00

SURF
(300 Boardwalk)

Single Rooms	\$ 7.50
Double Rooms	\$13.00

MOTELS**FILSON**
(1753 Jackson St.)

Single Rooms	\$ 4.00
Double Rooms	\$ 5.00

DILLOWS
(1831 Plunkett St.)

Single Rooms	\$ 3.50
Double Rooms	\$ 4.00
One bedroom apartments	(weekly) \$35.00-40.00

APARTMENTS**NEPTUNE**

(2012 N. Surf Rd.)

Efficiency Apartments	(weekly) \$75.00
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MERMAID

(319 Pierce St.)

Efficiency Apartments	(daily) \$ 8.00- 9.00
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BEACH AND TOWN
(1010 S. Federal)

Double Rooms	\$ 8.50
Efficiency Apartments	(daily) \$10.00

TECHNICAL EXHIBITS

Technical exhibits will be located in the Great Lounge of the Hollywood Beach Hotel. The technical exhibits have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way. Many exhibitors have nothing to sell, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Hollywood meeting:

Booth	Exhibitor
1.	Lederle Laboratories Division
2.	Westinghouse X-Ray Division
3.	H. G. Fischer & Co.
4-5.	Sealy, Incorporated
6.	G. D. Searle & Co.
8.	Brayten Pharmaceutical Co.
9.	The National Drug Company
10.	Keleket X-Ray of Florida
11.	Tablerock Laboratories
12.	C. B. Fleet Co.
13-14.	The Coca-Cola Company
15.	Burroughs-Wellcome & Co., Inc.
16.	The Upjohn Company
18.	The Nestlé Co., Inc.
19.	E. R. Squibb & Sons
20.	Picker X-Ray Corp.
21.	Professional Insurance Corp.
22.	Camel Cigarettes
23.	Winthrop-Stearns, Inc.
24.	American Optical Company
25.	Chas. Pfizer & Co., Inc.
26.	Pet Milk Company
27-28.	Surgical Equipment Co.
29.	Parco Surgical Supplies
30.	White Laboratories, Inc.
31.	Abbott Laboratories
32.	A. S. Aloe Company
33.	Schering Corporation
34.	Mead Johnson & Company
35.	Ortho Pharmaceutical Corporation
36.	Hoffman-LaRoche, Inc.
39.	The Wm. S. Merrell Company
40.	Amedic Surgical Company
41.	Walker Vitamin Products, Inc.
42.	Wyeth, Incorporated
43.	Ciba Pharmaceutical Products, Inc.
44.	The Borden Company
45.	Anderson Surgical Supply Company
46.	General Electric X-Ray Corp.
47.	Sharp and Dohme, Inc.
48.	Sandoz Pharmaceuticals
49.	M & R Dietetic Laboratories
50.	Holland-Rantos Company
51-52.	Medical Supply Company
53.	Eli Lilly and Company
54.	Medco Products Company
55.	Parke, Davis & Co.
56.	U. S. Vitamin Corp.
57.	J. A. Majors Company
62.	Carnation Company

SCIENTIFIC EXHIBITS

The scientific exhibits will be located in the Great Lounge of the headquarters hotel. We consider ourselves fortunate to be able to present for your approval the following exhibits:

- 1 F.M.A. Committee on Tuberculosis and Public Health. Erasmus B. Hardee, M.D., Vero Beach.
- 2 Florida State Board of Health. Wilson T. Sowder, M.D., Jacksonville.
- 3-4 Skin Cancer of the Face. Wesley W. Wilson, M.D., Tampa.
- 5-6 The Fenestration Operation. J. Brown Farrior, M.D., Tampa.
- 7 Public Relations, Florida Medical Association. Joseph S. Stewart, M.D., Miami.
- 8 Percutaneous Cerebral Angiography. Alfred G. Levin, M.D., Miami, David Kirsh, M.D., Miami, Theodore M. Berman, M.D., Miami Beach, Joseph H. Lucinian, M.D., Miami, Richard E. Strain, M.D., Miami, and Irwin Perlmutter, M.D., Miami.
- 9 Diabetes in Pregnancy. George F. Schmitt, Jr., M.D., Miami.
- 10 Foreign Bodies in the Larynx, Tracheobronchial Tree and Esophagus. Nathaniel M. Levin, M.D., Miami.
- 11 Carcinoma of the Lung. Leffie M. Carlton, Jr., M.D., Tampa.
- 12 Florida Academy of General Practice. Henry L. Harrell, M.D., Ocala.
- 13 Florida Medical Service (Blue Shield). Leigh F. Robinson, M.D., Ft. Lauderdale.
- 60 Rhinoplasty. Benjamin G. Pollock, M.D., Miami.
- 61 Surgery of the Esophagus. DeWitt C. Daughtry, M.D., Miami.

WINNERS OF THE ORLANDO LOVING CUP

The Orlando Loving Cup was donated by the Orange County Medical Society at the Annual Meeting of the Florida Medical Association in 1931 at Orlando.

- 1931—M. A. Lischkoff, Pensacola
- 1932—Clarence A. Rudisill, Tampa
- 1933—Blackburn W. Lowry, Tampa
- 1934—Hayward J. Blackmon, Tampa
- 1935—M. A. Lischkoff, Pensacola
- 1936—Shaler Richardson, Jacksonville
- 1937—J. R. Chandler, Daytona Beach
- 1938—William Y. Sayad, West Palm Beach
- 1939—James T. Cowart, Tampa
- 1940—Lucien B. Dickerson, Clearwater
- 1941—William C. Roberts, Panama City
- 1942—Clarence A. Rudisill, Tampa
- 1943—No tournament (war)
- 1944—No tournament (war)
- 1945—No tournament (war)
- 1946—Walter C. Jones, Miami
- 1947—Walter F. Davey, Stuart
- 1948—Robert D. Harris, Jr., St. Augustine
- 1949—Dodge D. Mentzer, Lakeland
- 1950—William G. Meriwether, Plant City

CONVENTION COMMITTEES

CABINET

Milton N. Camp, *Chairman*
 Russell B. Carson Robert R. Harriss
 Lloyd U. Lumpkin Dale T. Anstine
 Benjamin F. Hart Curtis H. Sory
 S. Elliott Wilson Julius F. Boettner
 Robert B. McIver

SMOKER

Russell B. Carson, *Chairman*
 Mark Butler Robert J. Patterson
 Burns A. Dobbins, Jr. William D. Wells

GOLF

Lloyd U. Lumpkin, *Chairman*
 Curtis D. Benton, Jr. Francis D. Pierce
 Henry J. Peavy Randall W. Snow

ANGLERS

Benjamin F. Hart, *Chairman*
 E. Borland Gill Kenneth W. Schenck
 Daniel D. Peschio Alva R. Taylor

TRAPSHOOTERS

S. Elliott Wilson, *Chairman*
 Alfred E. Cronkite Roland F. Fisher
 Robert L. Elliston Donald H. Gahagen

HOTELS AND RATES

Robert R. Harriss, *Chairman*
 Miles J. Bielek Walter J. Glenn, Jr.
 Fred E. Brammer Royle B. Klinkenberg

TRANSPORTATION

Dale T. Anstine, *Chairman*
 Thomas L. McKee Claus A. Peterson
 Albert A. Parrish Ernest E. Serrano

WOMAN'S AUXILIARY ADVISORY

Curtis H. Sory, *Chairman*
 Garland M. Johnson Thomas L. Roberts, Jr.
 Richard A. Mills Scottie J. Wilson

FINANCE

Julius F. Boettner, *Chairman*
 Norris M. Beasley Thomas F. Huey, Jr.
 Robert E. Blount Raymond M. Price

ASSOCIATION DINNER

Robert B. McIver, *Chairman*
 Herbert E. White David R. Murphey, Jr.

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:00 p.m.

HOLLYWOOD BEACH HOTEL — DINING ROOMS

EMORY

6:00 p.m. Supper and program
 Northeast Dining Room

TULANE

6:00 p.m. Supper on the Ocean Terrace
 8:00 p.m. Program in the Theatre

GEORGIA

6:00 p.m. Supper — Northwest Section
 Main Dining Room

OTHER A. AND F. SUPPERS

6:00 p.m. Contact the Dining Room Head Waiter, J. W. McGuire, before 5:00 p.m. Monday for reservations in a section of the main dining room and give him the approximate number of plates to be served.

MONDAY**FIRST GENERAL SESSION***Monday, 9:30 to 9:45 a.m.*

HOLLYWOOD BEACH HOTEL—THE SUN ROOM
 Call to Order, Herbert E. White, President
 Invocation, The Reverend Robert E. Fry, D.D., Pastor,
 Hollywood Presbyterian Church
 Address of Welcome, M. Austin Lovejoy, President, Brow-
 ard County Medical Society
 Announcements
 Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Frederick K. Herpel,
 Chairman, West Palm Beach; Hardgrove S. Norris, St.
 Augustine; Jere W. Annis, Lakeland; James L. Borland,
 Jacksonville; Carol C. Webb, Pensacola.

Attention is called to the following By-Laws:

*"All papers read before the Association shall be its
 property. Every paper shall be deposited with the secre-
 tary when read."*

*"No address or paper before the Association, except
 those of the president and orator, shall occupy more than
 fifteen minutes in its delivery, and no member shall speak
 longer than five minutes, or more than once on any one
 subject."*

FIRST SCIENTIFIC ASSEMBLY*Monday, 9:45 to 11:45 a.m.*

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

- 9:45 a.m. "Massive Resection of the Small Intestines,
 with Follow-Up Study of a Case," Julien C.
 Pate, and Julien C. Pate, Jr., Tampa.
 Discussion: Edward Jelks, Jacksonville
 Walter C. Jones, Miami
- 10:15 a.m. "The Use of Tantalum Mesh in the Repair of
 Inguinal Hernias" (2" x 2" Slides), Joseph
 Canipelli and Edward Canipelli, Jacksonville
- 10:45 a.m. "Melanoma and Carcinoid of the Rectum"
 (3 1/4" x 4" Slides), Curtis Rosser, Professor
 of Proctology, Southwestern Foundation
 School of Medicine, Dallas, Texas.
- 11:15 a.m. "Treatment of Urinary Frequency in Women,"
 Joseph C. Hayward, Louis M. Orr, II, and
 James B. Glanton, Orlando.

**AMERICAN COLLEGE OF PHYSICIANS
LUNCHEON***Monday, 12:30 p.m.*

HOLLYWOOD BEACH HOTEL—SECTION MAIN DINING ROOM
 Fellows and Associates are urged to be present.

SECOND GENERAL SESSION*Monday, 2:00 p.m.*

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

Call to Order, Herbert E. White, President
 Report of Secretary-Treasurer, Robert B. McIver, and
 Managing Director, Stewart G. Thompson
 Gavel to First Vice President, Richard A. Mills
 President's Address, Herbert E. White
 President Resumes Chair
 Introduction, Delegates from other state societies
 New Business
 Announcements
 Adjournment

SECOND SCIENTIFIC ASSEMBLY*Monday, 3:30 to 5:30 p.m.*

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

- 3:30 p.m. "Antibiotics in the Treatment of Urinary Infec-
 tions" (3 1/4" x 4" Slides), Grayson Carroll,
 Associate Professor of Urology, St. Louis Uni-
 versity, St. Louis, Missouri.
- 4:00 p.m. "Cerebral Arteriography" (3 1/4" x 4" Slides),
 Maurice M. Greenfield and Christian Keedy,
 Miami.
- 4:30 p.m. "Endocrine Relationships in Diabetes Mellitus
 and Carbohydrate Metabolism," Sidney David-
 son, Lake Worth.
- 5:00 p.m. Paper Withdrawn by Essayist.

ALUMNI AND FRATERNITY SUPPERS*Monday, 6:00 p.m.*

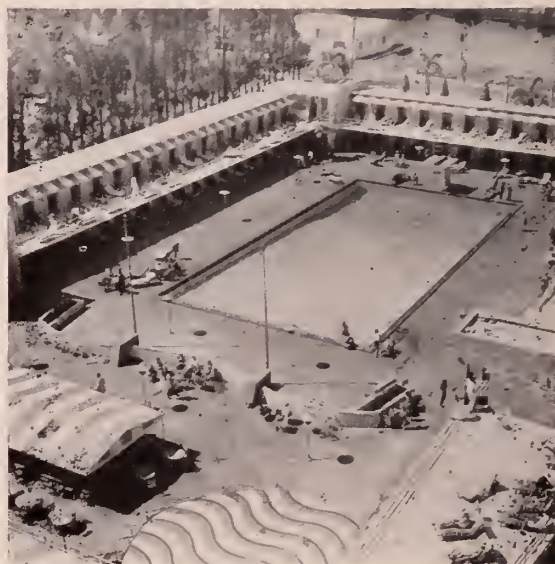
HOLLYWOOD BEACH HOTEL—DINING ROOMS

*(See page 569)***SMOKER (Not Stag)***Monday, 9:00 p.m.*

HOLLYWOOD BEACH HOTEL—CABANAS AND POOL

Hear ye! Hear ye! The Carnival is open tonight.
 Games and prizes, food, drink, dancing. The greatest show
 on earth. Step right up, ladies and gentlemen. Arrange-
 ments have been made by the Smoker Committee, of
 which Dr. Russell B. Carson is chairman.

Smoker privileges will be \$3.00. You can't beat it.
 Get your tag before 5:30 p.m. at the Registration Desk
 in the Exhibit Hall. Come one—come all.

**Pool and Cabana Terrace**

TUESDAY

FIRST MEETING HOUSE OF DELEGATES

Tuesday, 9:30 a.m.

HOLLYWOOD BEACH HOTEL — THE SUN ROOM

Delegates assemble at the Credentials Committee table at entrance of The Sun Room at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Louis M. Orr, II, Chairman
John D. Milton
David R. Murphey, Jr.

Delegates are to occupy seats in the section designated in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in another section of the room.

9:30 a.m., President White in the Chair

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee

Motion to seat Delegates if a quorum is present

Adoption of Minutes as published in June 1950 Journal

Election of one Delegate and one Alternate to A.M.A. House of Delegates for two year terms

Election of a third Delegate and a third Alternate to A.M.A. House of Delegates with terms beginning with calendar year, 1951. The Terms to be two calendar years or such portion thereof as the Association is entitled to a third Delegate. (The Association will be entitled to only two delegates if the number of active members falls below 2001 by the A.M.A. count.)

(A.M.A. By-Laws, Chapter I, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.")

Reference Committee Personnel announced by President
Presentation of Resolutions (*Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.*)

Reports of Committee Chairmen:

(To Reference Committee No. 1)

Scientific Work, Frederick K. Herpel
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton
Venereal Disease Control, Wiley M. Sams
Tuberculosis and Public Health, Erasmus B. Hardee
Maternal Welfare, E. Frank McCall
Child Health, Manuel A. Perez

(To Reference Committee No. 2)

Conservation of Vision, W. Jerome Knauer
Legislation and Public Policy, Eugene G. Peek, Sr.
Medical Education and Hospitals, Vernon A. Lockwood
Public Relations and State Education Campaign, Joseph S. Stewart

Medical Economics, H. Quillian Jones
State Controlled Medical Institutions, William H. McCullagh

Representatives to Industrial Council, G. Frederick Oetjen

Grievance, Walter C. Payne

(To Reference Committee No. 3)

Board of Governors, Herbert E. White
Interrelationship, Henry J. Peavy
Necrology, Joseph Halton
Advisory to Woman's Auxiliary, James L. Anderson
Councilor Districts and Council, Lloyd J. Netto
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James L. Borland

New Business
Announcements
Adjournment

THIRD GENERAL SESSION

Tuesday, 11:30 a.m.

HOLLYWOOD BEACH HOTEL — THE SUN ROOM

Call to Order, Herbert E. White, President

Address (By Invitation), "Surgery of the Biliary Tract, a Personal Experience with Nine Hundred Consecutive Cases in Private Practice" (3 1/4" x 4" Slides), Lon Grove, Associate Professor of Clinical Surgery, Emory University School of Medicine, Atlanta

Adjournment

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 2:00 to 4:30 p.m.

HOLLYWOOD BEACH HOTEL — THE SUN ROOM

2:00 p.m. "Disabling Conditions of the Cervical Spine" (3 1/4" x 4" Slides), Fred H. Albee, Jr, Orlando.
Discussion: Eugene L. Jewett, Orlando

John F. Lovejoy, Jacksonville

2:30 p.m. "Medical Care Problems in Poliomyelitis" (3 1/4" x 4" Slides), Kenneth S. Landauer, Director of Medical Services, The National Foundation for Infantile Paralysis, New York.

3:00 p.m. "Experience in Surgery of the Common Bile Duct" (2" x 2" Slides), Alpheus T. Kennedy, Pensacola.

3:30 p.m. "Strokes; Their Diagnosis and Treatment" (2" x 2" Slides), Richard E. Strain and Irwin Perlmutter, Miami.

Discussion: Alfred G. Levin, Miami
Mason Trupp, Tampa

4:00 p.m. "Malignancy During Pregnancy" (2" x 2" Slides), Henry L. Harrell, Ocala.

REFERENCE COMMITTEES

Tuesday, 2:30 p.m.

HOLLYWOOD BEACH HOTEL

The three reference committees will meet on Tuesday at 2:30 p.m. in the N. E. Dining Room, S. W. Porch and Men's Card Room. The names of the delegates who have been appointed by President White to serve on reference committees are listed below:

1. HEALTH AND EDUCATION

N. E. DINING ROOM

Frederick K. Herpel, Chairman
Warren W. Quillian
Hardgrove S. Norris
William C. Roberts
Turner E. Cato

2. PUBLIC POLICY

S. W. PORCH

Walter C. Payne, Chairman
Reuben B. Chrisman, Jr.
James L. Borland
Herschel G. Cole
C. Robert DeArmas

3. FINANCE AND ADMINISTRATION

MEN'S CARD ROOM

Shaler Richardson, Chairman
Robert B. McIver
Homer L. Pearson, Jr.
Chas. L. Farrington
Duncan T. McEwan

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

HOLLYWOOD BEACH HOTEL — MAIN DINING ROOM

Those who are not lodging at the headquarters hotel may obtain dinner tickets (\$5.75 per person) from the hotel cashier.

VOUCHERS FOR PRIZES

At Association Dinner
Golf and Other Sports Events

WEDNESDAY

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.

HOLLYWOOD BEACH HOTEL — MAIN DINING ROOM

Frederick J. Waas, *Chairman*

Walter C. Payne, *Secretary*

Breakfast

Election of a Chairman and Secretary

(According to precedence, Dr. Julius C. Davis will succeed the present chairman and Dr. Herbert E. White the present secretary.)

FOURTH SCIENTIFIC ASSEMBLY

Wednesday, 9:00 to 10:30 a.m.

HOLLYWOOD BEACH HOTEL — THE SUN ROOM

9:00 a.m. "Carcinoma of the Prostrate" (2" x 2" Slides), Joseph Q. Perry, Pensacola.

Discussion: E. Clay Shaw, Miami

9:30 a.m. "The Advancing Field of Thoracic Surgery" (3 1/4" x 4" Slides), DeWitt C. Daughtry, Miami.

Discussion: John Chesney, Miami.

10:00 a.m. "Summary of Progress in the General Field of Health for the period 1940-1949" (2" x 2" Slides), Wilson T. Sowder, State Health Officer, Florida State Board of Health, Jacksonville.

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:30 a.m.

HOLLYWOOD BEACH HOTEL — THE SUN ROOM

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Louis M. Orr, II, Chairman, John D. Milton and David R. Murphey, Jr., located at entrance to The Sun Room. (*No Alternates are to be seated for Delegates attending yesterday's meeting.*)

President White in the Chair, 10:30 a.m.

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee

Recommendations of Reference Committees:

No. 1. Health and Education

Frederick K. Herpel, Chairman

No. 2. Public Policy

Walter C. Payne, Chairman

No. 3. Finance and Administration

Shaler Richardson, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon

President-elect

First Vice President

Second Vice President

Third Vice President

Secretary-Treasurer

Editor of The Journal

Dr. David R. Murphey, Jr., escorted to the Chair as new President

Presentation of Past President's Button and Certificate of Honor to Dr. Herbert E. White by Dr. David R. Murphey, Jr., President

Adjournment

SPECIALTY GROUP MEETINGS

Saturday and Sunday, April 21-22

On July 25, 1948 the Board of Governors ruled that rooms be assigned to the various specialty group societies on Sunday, as heretofore, but that the State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

THIRD ANNUAL MEETING

FLORIDA ALLERGY SOCIETY

OFFICERS

Clarence Bernstein, President Orlando

George F. Hieber, Vice Pres. &

Pres.-elect St. Petersburg

Nelson Zivitz, Secy.-Treas Miami Beach

Sunday, April 22

HOLLYWOOD BEACH HOTEL — SPORTS CENTER

8:00 p.m. 1. "Allergic Reactions of the Lungs. Its Different Forms and Diagnosis," (by invitation) Jose M. Quintero Fossas, Havana, Cuba.

2. "Agglutination Tests for Allergens," William H. Gardner, West Palm Beach.

Open Discussion

3. "Allergy from the Otolaryngologist's Viewpoint," Frederick D. Droegge, Sarasota.

Open Discussion.

4. "Pollen and Spore Survey of the Miami Beach District for 1948 and 1949," Lewis Palay, Miami Beach.

Open Discussion.

THIRD ANNUAL MEETING

FLORIDA SOCIETY OF ANESTHESIOLOGISTS

OFFICERS

Ralph S. Sappenfield, President Miami

Harold Carron, President-elect Tampa

John T. Stage, Vice President Jacksonville

Adelbert F. Schirmer, Secy.-Treas. Orlando

Sunday, April 22

HOLLYWOOD BEACH HOTEL — "A" DANCE STUDIO

2:30 p.m. Scientific Meeting

Business Meeting

Election of Officers

THIRD ANNUAL MEETING

FLORIDA CHAPTER

AMERICAN COLLEGE OF CHEST PHYSICIANS

OFFICERS

Arnold S. Anderson, President St. Petersburg

Alexander Libow, Secy.-Treas. Miami Beach

Nathaniel M. Levin, Program Chairman Miami

Sunday, April 22

HOLLYWOOD BEACH HOTEL — SPORTS CENTER

10:00 a.m. Business Meeting

1. "Non-tuberculous Pulmonary Pathology Detected on X-Ray Surveys," Clarence M. Sharp, Jacksonville.

2. "Antibiotics in the Treatment of Tuberculosis," Henry C. Sweany, Jacksonville.

3. Classification and Diagnosis of Medias-
tinal Tumors," Hawley H. Seiler, Orlando.
4. "Hemoptysis of Undetermined Origin,"
Nathaniel M. Levin, Miami.
5. "Congenital Cysts of the Lung," DeWitt C.
Daughtry, Miami.

Lunch — Main Dining Room

- 2:00 p.m. 6. "Cancer of the Lung," Jack Reiss, George
L. Baum and Maurice Kovnat, Miami.
7. X-Ray Round Table Discussion
M. Jay Flipse, Miami, Moderator

REGULAR MEETING OF THE FLORIDA ASSOCIATION OF

DERMATOLOGY AND SYPHILOLOGY

OFFICERS

Wesley W. Wilson, President Tampa
Lewis Capland, Vice President Miami Beach
Morris Waisman, Secy.-Treas Tampa

Sunday, April 22

Time and place to be announced

FIFTH ANNUAL MEETING

FLORIDA ACADEMY OF GENERAL PRACTICE

OFFICERS

T. D. Sandberg, President Coral Gables
Elmer E. Leitner, President-elect Jacksonville
Norris M. Beasley, Vice President Ft. Lauderdale
Vincent P. Corso, Secy.-Treas Miami

Sunday, April 22

HOLLYWOOD BEACH HOTEL — SUN ROOM

- 2:00 p.m. Scientific Session
"Sixty Years in the Practice of Medicine,"
Dr. Andy Hall, Mount Vernon, Illinois, A.M.A.
General Practitioner of the Year 1949.
- 3:00 p.m. Business Session

SIXTH ANNUAL MEETING

FLORIDA HEALTH OFFICERS' SOCIETY

OFFICERS

John M. McDonald, President Jacksonville
Terry Bird, Vice President Apalachicola
Lorenzo L. Parks, Secy.-Treas Jacksonville

Sunday, April 22

HOLLYWOOD BEACH HOTEL — S. W. PORCH

- 2:00 p.m. Scientific Session
1. "A Consolidated Screening Survey in Semi-
nole County," Malcolm J. Ford, Jackson-
ville.
Discussion: Frank L. Quillman, Sanford
 2. "Progress in Tuberculosis Control in Flori-
da," Clarence M. Sharp, Jacksonville.
Discussion: Rollin D. Thompson, Lantana
 3. "Epidemic Poliomyelitis and the Health
Officer," Ken Landauer, New York, N. Y.
 4. "Some Thoughts for a School Health Pro-
gram," Godfrey L. Beaumont, Sebring.
Discussion: Mildred Scott, Jacksonville
 5. "The Greeks Had a Word for It," George
A. Dame, Jacksonville.
 6. "Venereal Granulomas in Florida," Wesley
W. Wilson, Tampa.
Discussion: Lorenzo L. Parks, Jacksonville
 7. "Alcoholism as a Public Health Program,"
William G. Hollister, Atlanta, Ga.

THIRD ANNUAL MEETING FLORIDA HEART ASSOCIATION

OFFICERS

Louie Limbaugh, President Jacksonville
Elwyn Evans, President-elect Orlando
Jere W. Annis, Vice President Lakeland
H. Milton Rogers, Secretary St. Petersburg

Sunday, April 22

HOLLYWOOD BEACH HOTEL — FLAMINGO ROOM

- 1:30 p.m. Scientific Program
President's Address
"The Electrocardiographic Changes in Pulmo-
nary Embolism," David A. Newman, West
Palm Beach.
"Catheterization in Congenital Heart Disease,"
Dale L. Groom, Coral Gables.
Intermission
"Practical Medical Aspects of Peripheral Vas-
cular Disease," Earl R. Templeton, Miami
Beach.
"The Effects of Pernicious Anemia on the
Blood Flow and Metabolism of the Brain,"
Peritz Scheinberg, Miami.
"Relation of Tonsils to Systemic Disease In-
cluding Rheumatic Fever and Carditis," David
A. Nathan, Miami Beach.
Dinner — Main Dining Room
- 8:00 p.m. Program to be arranged — THEATRE

TWELFTH ANNUAL MEETING

FLORIDA ASSOCIATION OF INDUSTRIAL AND RAILWAY SURGEONS

OFFICERS

Frank D. Gray, President Orlando
Julius C. Davis, President-elect Quincy
G. Frederick Oetjen, Vice President Jacksonville
John H. Mitchell, Secy.-Treas. Jacksonville

Sunday, April 22

HOLLYWOOD BEACH HOTEL — THEATRE

- 4:30 p.m. President's Address
"Internal Fixation of Fractures of the Long
Bones" (By invitation), Julian K. Quattle-
baum, Chief Surgeon of Oglethorpe Sanatorium,
Savannah, Ga.
Round Table Discussion
Business Meeting and Election of Officers

SIXTH ANNUAL MEETING

FLORIDA MEDICAL SERVICE CORPORATION

OFFICERS

Leigh F. Robinson, President Ft. Lauderdale
Walter C. Jones, 1st Vice President Miami
Mother Loretta Mary, 2nd Vice President Tampa
Frederick J. Waas, Treasurer Jacksonville
Samuel M. Day, Jr., Asst. Treasurer Jacksonville
Herbert E. White, Secretary St. Augustine

Sunday, April 22

HOLLYWOOD BEACH HOTEL — N. E. DINING ROOM

10:00 a.m. Dr. Robinson presiding

FIFTH ANNUAL MEETING FLORIDA SOCIETY OF NEUROLOGY AND PSYCHIATRY

OFFICERS

James L. Anderson, President Miami
Samuel G. Hibbs, Vice President Tampa
William H. McCullagh, Secy.-Treas. Jacksonville

Sunday, April 22

HOLLYWOOD BEACH HOTEL—STOCK BROKERS' ROOM

4:00 p.m. Scientific Session

1. "The Status of Prefrontal Lobotomy with Case Reports," Samuel G. Hibbs, J. Robert Campbell, Ernest R. Bourkard, Tampa.
 2. "Electroencephalography in Neuro-Psychiatric Practice," Bernard Goodman, Miami
- Business Meeting and Election of Officers

FOURTH ANNUAL MEETING

FLORIDA OBSTETRIC AND GYNECOLOGIC SOCIETY

OFFICERS

Robert T. Spicer, President Miami
William C. Thomas, Sr., President-elect Gainesville
Dorothy D. Brame, Secy.-Treas. Orlando

Sunday, April 22

HOLLYWOOD BEACH HOTEL—N. E. DINING ROOM

2:00 p.m. Business Session—Election of Officers

Round Table Discussion, Hervey C. Williamson, Associate Professor Clinical Obstetrics and Gynecology, Cornell University, New York, leader.

7:00 p.m. Dinner—Main Dining Room

8:00 p.m. Scientific Session,

Hervey C. Williamson, guest speaker

TWELTH ANNUAL MEETING

FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

OFFICERS

R. Renfro Duke, President Tampa
Charles C. Grace, Vice President St. Augustine
Carl S. McLemore, Secy.-Treas. Orlando

Sunday, April 22

HOLLYWOOD BEACH HOTEL—THEATRE

10:00 a.m. Scientific Session

1. President's Address: "Report of a Case of Stevens-Johnson's Disease," R. Renfro Duke, Tampa.
2. "Diseases of the Parotid Gland," G. Dekle Taylor, Jacksonville.
Discussion: Walter T. Hotchkiss, Miami Beach
Charles C. Grace, St. Augustine
3. "Absorbable Post-Placed Sutures in Cataract Surgery," Joseph W. Taylor, Jr., Tampa.
Discussion: Joseph W. Taylor, Sr., Tampa
Charles W. Boyd, Jacksonville

Business Meeting

Annual Report of Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director, Tampa.

Presentation of Vocational Rehabilitation Program of Bucco-Esophageal Speech, W. J. Miller.

2:00 p.m. Scientific Session

1. "Contractures and Hypertrophies of Extraocular Muscles," (by invitation), Jack S. Guyton, Baltimore.
 2. "The Management of Early Malignancies of the Larynx," (by invitation), Francis E. LeJeune, New Orleans.
- Election of Officers

FIFTH ANNUAL MEETING FLORIDA ORTHOPEDIC SOCIETY

OFFICERS

Chas. L. Farrington, President St. Petersburg
John F. Lovejoy, Vice President Jacksonville
Herschel G. Cole, Secy.-Treas. Tampa

Sunday, April 22

HOLLYWOOD BEACH HOTEL—CABANA ROOM

2:00 p.m. Business Meeting

Election of Officers

NINTH ANNUAL MEETING FLORIDA PATHOLOGICAL SOCIETY

OFFICERS

Nelson A. Murray, President Jacksonville
Ira C. Evans, Vice President St. Petersburg
Gretchen V. Squires, Secy.-Treas. Pensacola

Sunday, April 22

HOLLYWOOD BEACH HOTEL—PUBLICITY OFFICE

9:00 a.m. General Business Session

Election of New Members

Election of Officers

2:00 p.m. General Session

8:00 p.m. Technical Problems

THIRTEENTH ANNUAL MEETING

FLORIDA STATE PEDIATRIC ASSOCIATION

OFFICERS

Edgar E. Hitchcock, President Orlando
Lewis T. Corum, Vice President Tampa
Charlotte C. Maguire, Secy.-Treas. Orlando

Sunday, April 22

HOLLYWOOD BEACH HOTEL—MEN'S CARD ROOM

2:00 p.m. Clinical Pediatric Lecture, Ralph Platou, New Orleans

4:00 p.m. Case Presentations by members to be selected
Business Meeting

8:00 p.m. Kodachrome slides of clinical value, Ralph Platou, New Orleans

FOURTH ANNUAL MEETING

FLORIDA PROCTOLOGIC SOCIETY

OFFICERS

Edward C. Watt, President Jacksonville
Charles E. Hebard, Vice President Tampa
George Williams, Jr., Secy.-Treas. Miami

Sunday, April 22

HOLLYWOOD BEACH HOTEL—"B" DANCE STUDIO

4:00 p.m. Business Meeting

8:00 p.m. Scientific Session

1. "Treatment of Ulcerative Colitis with ACTH; Case Report," Sol Selevan, Miami Beach.
2. "Chemical Stricture of the Rectum, with Case Report," George Williams, Jr. Miami.
3. "Management of Colostomy," (by invitation), Curtice Rosser, Dallas, Texas.

TWENTIETH ANNUAL SPRING MEETING

FLORIDA RADIOLOGICAL SOCIETY

OFFICERS

Floyd K. Hurt, President Jacksonville
John J. McGuire, Vice President Pensacola
Thomas H. Lipscomb, Secy.-Treas. Jacksonville

Saturday, April 21

HOLLYWOOD BEACH HOTEL—THEATRE

3:00 p.m. Round Table Discussion—Diagnosis

8:00 p.m. Round Table Discussion—Therapy

Sunday, April 22

HOLLYWOOD BEACH HOTEL—MEN'S CARD ROOM

9:00 a.m. Business Session and Election of Officers

FOURTH ANNUAL MEETING
FLORIDA UROLOGICAL SOCIETY

OFFICERS

Alvin L. Mills, President St. Petersburg
Lee Sharp, President-elect..... Pensacola
George H. Putnam, Secy.-Treas. Gainesville

Sunday, April 22

HOLLYWOOD BEACH HOTEL — THE SUN ROOM

8:00 p.m. "Urea Splitting Organisms in the Formation of Urinary Calculi" (by invitation), Grayson Carroll, St. Louis, Missouri.
"Pyelographic Clinic," Grayson Carroll, St. Louis, Moderator
Business Meeting
Election of Officers

TWENTY-FOURTH ANNUAL MEETING

WOMAN'S AUXILIARY

CONVENTION COMMITTEE

Mrs. Oden A. Schaeffer, *Chairman*
Mrs. Herbert W. Virgin, Jr. Mrs. Donald F. Marion
Mrs. C. Russell Morgan, Jr. Mrs. Arthur B. Connor

REGISTRATION

East End of the Exhibit Hall

The Registration Desk will be located at the East end of the Exhibit Hall and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 1:00 p.m. Auxiliary members and guests will be required to register and obtain their identification badges before attending any of the functions. Doctors' wives are invited to attend all activities of the Auxiliary.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay \$3.00 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Cabañas and Pool at 9:00 p.m. Monday and worn throughout the evening.

ANNUAL PROGRAM

Sunday, April 22

HOLLYWOOD BEACH HOTEL — LADIES' CARD ROOM

2:30 p.m. Executive Board Meeting

HOLLYWOOD BEACH HOTEL — FLAMINGO ROOM

8:30 p.m. Special Entertainment
(Doctors also cordially invited)

Monday, April 23

HOLLYWOOD BEACH HOTEL — THEATRE

9:30 a.m. General Auxiliary Session

HOLLYWOOD BEACH HOTEL — N. E. DINING ROOM

12:30 p.m. Annual Luncheon honoring Mrs. Arthur Herold, President of the Auxiliary to the American Medical Association and Mrs. L. P. Thompson, President of the Auxiliary to the Southern Medical Association.

Speaker — Dr. Homer L. Pearson, Jr.

Special Guests — Dr. and Mrs. Herbert E. White, Dr. and Mrs. David R. Murphey, Jr.

2:30-5:00 p.m. Sight seeing and shopping tours arranged for those who wish — sign at information desk in hotel lobby.

Tuesday, April 24

HOLLYWOOD BEACH HOTEL — LADIES' CARD ROOM

9:30 a.m. Post Convention Executive Board Meeting

Advertisement



From where I sit
by Joe Marsh

Slim and His "Ali Species"

Slim Baker, who's always doing something crazy, had a lot of people smiling last week all because his entry won a blue ribbon in the Women's Club Annual Pet Show.

Seems as though Slim saw a strange-colored alley cat with no tail and brought it home. He washed, combed, and brushed it and put a collar on the cat with a card reading "Ali Species." Then he enters it in the show.

Hanged if the ladies didn't think it was some rare kind of cat and gave it a special award! When one of them asked Slim where she could get one like it, he said, "It's all yours, M'am — I can pick up an 'Alley Cat' any time I want to!"

From where I sit, some of us are often easily "taken in" on someone else's say-so. Whether awarding prizes, passing judgment on how a man should follow his profession, or questioning our neighbor's preference for a glass of beer—let's take a look from stem to stern before making any final decision on the matter.

Joe Marsh

The Program
of the
Seventy-Seventh
Annual Convention
Hollywood Beach Hotel
April 22-25, 1951
Appears on the
Preceding Pages

ADDITIONAL COMMITTEES
GRIEVANCE

WALTER C. PAYNE, M.D., Chm.....Pensacola
JOSEPH S. STEWART, M.D.....Miami
WILLIAM C. THOMAS, M.D.....Gainesville
SHALER RICHARDSON, M.D.....Jacksonville
JOHN R. BOLING, M.D.....Tampa

ADVISORY TO SELECTIVE SERVICE
FOR PHYSICIANS AND ALLIED SPECIALISTS

J. ROCHER CHAPPELL, M.D., Chm.....Orlando
THOMAS H. BATES, M.D...."A".....Lake City
JOHN E. MAINES, JR., M.D...."B".....Gainesville
ALVIN L. MILLS, M.D...."C".....St. Petersburg
DONALD W. SMITH, M.D...."D".....Miami

EMERGENCY MEDICAL SERVICE

JAMES L. BORLAND, M.D., Chm.....Jacksonville
MERRITT R. CLEMENTS, M.D...."A".....Tallahassee
VERNON A. LOCKWOOD, M.D...."B".....St. Augustine
HERSCHEL G. COLE, M.D...."C".....Tampa
FREDERICK K. HERPEL, M.D...."D".....West Palm Beach

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

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DAVID R. MURPHEY, JR., M.D., President elect...Tampa
RICHARD A. MILLS, M.D., 1st Vice Pres...Ft. Lauderdale
WALTER C. PAGE, M.D., 2nd Vice Pres.....Cocoa
JAMES H. POUND, M.D., 3rd Vice Pres.....Tallahassee
ROBERT B. MCIVER, M.D., Sec'y-Treas.....Jacksonville
SHALER RICHARDSON, M.D., Editor.....Jacksonville

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....Jacksonville
ERNEST R. GIBSON, Assistant.....Jacksonville

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***SUB-COMMITTEES**

1. Veterans Care

FREDERICK H. BOWEN, M.D., Chm.....Jacksonville
A. JUDSON GRAVES, M.D.....Jacksonville
DOUGLAS D. MARTIN, M.D.....Tampa
EDWARD F. FOX, M.D.....Miami

2. Liaison—National Foundation Infantile Paralysis

FREDERICK H. BOWEN, M.D., Chm.....Jacksonville
A. JUDSON GRAVES, M.D.....Jacksonville
DOUGLAS D. MARTIN, M.D.....Tampa
EDWARD F. FOX, M.D.....Miami

3. Review of Fee Schedules

JOHN D. MILTON, M.D., Chm.....Miami
THOMAS C. BATES, M.D.....Lake City
FREDERICK H. BOWEN, M.D.....Jacksonville
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HAROLD G. NIX, M.D.....Tampa
JACK O. W. RASH, M.D.....Miami
KENNETH S. WHITMER, M.D.....Miami

4. Blue Shield

LEIGH F. ROBINSON, M.D., Chm.....Ft. Lauderdale

SCIENTIFIC WORK

FREDERICK K. HERPEL, M.D., Chm...D-54...W. Palm Beach
HARDGROVE S. NORRIS, M.D....AL-51.....St. Augustine
JERE W. ANNIS, M.D....C-51.....Lakeland
JAMES L. BORLAND, M.D....B-52.....Jacksonville
CAROL C. WEBB, M.D....A-53.....Pensacola

LEGISLATION AND PUBLIC POLICY

EUGENE G. PEEK, SR., M.D., Chm...B-54.....Ocala
H. PHILLIP HAMPTON, M.D....AL-51.....Tampa
WILLIAM M. DAVIS, M.D....C-51.....St. Petersburg
RUSSELL B. CARSON, M.D....D-52.....Ft. Lauderdale
DANIEL A. MCKINNON, M.D....A-53.....Marianna
HERBERT E. WHITE, M.D. (Ex Officio)....St. Augustine
ROBERT B. MCIVER, M.D. (Ex Officio)....Jacksonville

MEDICAL EDUCATION AND HOSPITALS*

VERNON A. LOCKWOOD, M.D., Chm...AL-51...*St. Augustine*
ALVORD L. STONE, M.D...C-51...*Tampa*
THOMAS C. KENASTON, M.D...B-52...*Cocoa*
JULIUS C. DAVIS, M.D...A-53...*Quincy*
ERBERT McLAURY, M.D...D-54...*Hollywood*

*SPECIAL ASSIGNMENTS

1. Rural Medical Service

PUBLIC RELATIONS*

JOSEPH S. STEWART, M.D., Chm...AL-51...*Miami*
EDWIN H. ANDREWS, M.D...B-51...*Gainesville*
FRANCIS T. HOLLAND, M.D...A-52...*Tallahassee*
LEIGH F. ROBINSON, M.D...D-53...*Ft. Lauderdale*
HOWARD V. WEEMS, Sr., M.D...C-54...*Sebring*

*SUB-COMMITTEE

1. State Education Campaign

JOSEPH S. STEWART, M.D., Chm...*Miami*
WALTER C. PAYNE, M.D...*Pensacola*
HOMER L. PEARSON, JR., M.D...*Miami*

NECROLOGY

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LON GROVE, M.D., GUEST SPEAKER

A native of Alabama, Dr. Lon Grove was born at Panola in 1890. He received his medical degree from the University of Alabama School of Medicine in 1912, and through the years has engaged in postgraduate studies at the University of Pennsylvania School of Medicine and other leading medical centers in this country and Europe.

Soon after finishing his hospital training, Dr. Grove entered military service and was first stationed at Walter Reed Hospital in Washington, D. C. Later he served at Red Cross Hospital No. 1 in Neuilly, France, and then became Chief of the Surgical Division, United States Base Hospital No. 202 at Orléans, France, with the rank of major. At the close of World War I, in October 1918 he was decorated by the French government for distinguished service to France.

Upon returning to the United States, Dr. Grove joined the teaching staff of Columbia University College of Physicians and Surgeons. Since November 1919 he has engaged in the practice of surgery in Atlanta, Ga., specializing in abdominal surgery. He is attending surgeon at Emory University Hospital, Chief of Surgery at Henrietta Egleston Memorial Hospital for Children and on the staff of several other Atlanta hospitals.

This eminent surgeon has for many years been a member of the faculty of Emory University School of Medicine, where he is now Associate Professor of Clinical Surgery. He is permanently identified at Emory University by his portrait, painted by Robert Brackman and presented by friends, which hangs in the main lobby of Emory University Hospital. The Atlanta press heralds him as "an important influence in establishing Emory University on the high pinnacle it occupies today" and lauds him "not only for his skill and greatness as a surgeon, but for his modesty, simplicity, understanding and greatness as a human being."

A member of the Founders Group of the American Board of Surgery, Dr. Grove is a member of the Southern Surgical Association and also holds a life membership in the American College of Surgeons. He is a member of numerous other medical organizations and is a frequent contributor to several national surgical publications.

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Seventy-Seventh Annual Meeting

Luxurious Hollywood Beach Hotel will again completely house the activities of the Florida Medical Association during its Seventy-seventh annual meeting, April 23-25. The hotel will provide transportation to its golf course for the members participating in the handicap tournament. The ideally designed Sun Room will be the scene of the three General Sessions, four Scientific Assemblies and the two meetings of the House of Delegates. The complete program is published in preceding pages of this number of The Journal.

This year will see eighteen specialty groups convening during the weekend preceding the opening of the Association's meeting. All groups will hold one or more sessions on Sunday. One specialty society is scheduled for Saturday as well. Each group has been assigned a meeting room of such size as will be adequate for the attendance anticipated. The program for each of these groups appears in this issue.

Dr. Frederick K. Herpel, chairman of the Association's Committee on Scientific Work, together with the members of his committee, Drs. Hardgrove S. Norris, Jere W. Annis, James L. Borland and Carol C. Webb, has prepared the program for the scientific assemblies. This year there will be four scientific assembly meetings, one each on Monday forenoon and afternoon and on Tuesday afternoon and Wednesday morning. Many of the specialty societies will be represented on the Association's scientific program by out-of-state speak-

ers who will have previously addressed specialty groups.

Dr. Russell B. Carson, chairman of the Smoker Committee and the members of his committee, Drs. Mark Butler, Burns A. Dobbins, Jr., Robert J. Patterson and William D. Wells, have completed arrangements for the annual Smoker on Monday night, April 23. A carnival atmosphere will predominate in the tropical outdoors of the Cabañas and Pool. Another event of the same evening at 6:00 p.m. will be the Alumni and Fraternity Suppers in the hotel dining rooms.

The annual dinner of the Association is scheduled for Tuesday night at the hotel. In addition to participating in these social events featured annually, the members and their guests will have opportunity for diversified entertainment and recreation which will include golf, trap shooting, ocean and pool bathing, fishing and sea or shore exploratory excursions.

The Great Lounge of the hotel overlooking the ocean has been given over to the scientific and technical exhibits. Scientific exhibits will present a wealth of information of value to specialists and general practitioners alike. The numerous technical exhibitis will invite careful inspection. Attendants will be on hand at each booth to answer questions on the latest developments in equipment, drugs and other products displayed by the exhibiting firms.

Notice to Delegates and Committee Chairmen

The House of Delegates will hold its first 1951 meeting on Tuesday, April 24, at 9:30 a.m. in the Sun Room of the Hollywood Beach Hotel. The delegates are requested to assemble at the Credentials Committee table at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges. This table will be located at the entrance to the Sun Room. Delegates are to occupy seats in the designated section in order that they may be grouped together. Other members of the Association and guest doctors are requested to occupy seats in another section of the room.

Chairmen of standing committees are urgently requested to be present on time so that their reports may be presented as scheduled in the official program, which is published in this issue of *The Journal*. Resolutions not included in the House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.

It is highly important that delegates and committee chairmen note the time, the date and the place of this first meeting of the House of Delegates. Register at 9:00 a.m. and convene at 9:30 a.m., Tuesday, April 24, in the Sun Room of the Hollywood Beach Hotel.

The second meeting of the House of Delegates will be held Wednesday, April 25, at 10:30 a.m. Delegates are required to fill out attendance cards for this meeting at 10:00 a.m. at the entrance to the Sun Room. These cards are the delegates' official attendance records. The By-Laws prohibit an alternate from serving for any delegate who was seated at the first meeting of the House.

At 12:00 noon on Wednesday, at this second meeting of the House, the election of officers of the Association for the ensuing year will take place.

This Journal contains the complete program for the Seventy-Seventh Annual Meeting at Hollywood — April 22-25.

American Medical Education Foundation

The recent action of the Board of Trustees of the American Medical Association in appropriating \$500,000 as the initial contribution to an annual fund to be raised by the medical profession to assist the medical schools of this country has properly received wide acclaim. It has now been announced that the American Medical Education Foundation has been established as a not-for-profit corporation to receive and distribute contributions to the fund from individual members of the medical profession and from friends of the profession. The distribution of the funds to all approved medical schools will be handled by an 11 man board of directors selected from the Board of Trustees, officers and Council on Medical Education and Hospitals of the American Medical Association.

This constructive and important step to thwart the dangers inherent in increasing federal financing of education is not only laudable but most timely. "There is growing public awareness," declared Dr. Louis H. Bauer, Chairman of the Board of Trustees, "that federal subsidy has come to be a burden, not a bounty, for it is bringing intolerable increases in taxation, and is dangerously increasing federal controls over our institutions and the lives of our people." Actually, who provides the "gifts" of federal money? The taxpayer, of course. They are, then, not gifts at all. And what price "gifts" to the recipients? They pay for them with their independence; according as they accept, they sell out to a horde of eager, arrogant federal bureaucrats.

The alternative? Private enterprise must finance the medical schools of this country if they are to remain free and unfettered by the governmental subsidy snare. In its patriotic effort to lead the way, the American Medical Education Foundation will need the help of all believers in free enterprise within the profession and many more outside its ranks. The money must come, not from millionaires who have all but vanished, but from the middle income group—men who believe in the American way of life and are willing to pay for what they profess.

Accordingly, the members of the medical profession, first of all, are counted upon to contribute promptly and generously to this new undertaking. Each physician is urged to consider an annual contribution of \$100. Many will wish to give more; some will consider this amount beyond their means, but will desire to contribute according to their

ability. All must realize, however, that substantial amounts on a yearly basis, not mere token contributions, will be required to meet this challenge and measure up to the opportunity offered.

Rising costs, inflation, fewer large individual benefactions and reduced income from endowments have placed the medical schools in need of immediate assistance. It is highly desirous, therefore, that the first annual disbursement of funds be made this spring. The key to success in this fund-raising campaign rests with the state and county medical societies. Stimulation from these levels must reach out at once to the physicians in every city, town and village.

It is important to remember that there are no strings attached to the aid granted from this fund to the 79 approved medical schools throughout the nation. Each school will be free to determine how it best can use its share to further the basic training of its students. It is likewise important — exceedingly so — to remember that failure to raise enough to remedy adequately the plight of these hard-pressed schools would be meat and drink to current purveyors of political and social nostrums who would pervert medical education into an instrument for the advancement of state medicine.

March Anniversaries

MARCH 1. Moses, the father of public health and hygiene, is thought to have been born on March 1, 1560 and to have died on March 1, 1480 B.C. The Jews were distinguished among the nations of that day for their belief in and practice of public hygiene. Their regulations dealt with leprosy, isolation of the sick, time of burial, location of cemeteries, marriage, and bathing. Moses made sanitary regulations governing slaughter of animals and preparation of food.

MARCH 3. Fritz Schaudinn first demonstrated *Treponema pallidum* to his co-workers at the Imperial Board of Health in Berlin on March 3, 1905. Schaudinn's extraordinary skill in protozoologic technic paved the way for Metchnikoff and Ehrlich and for the eventual conquest of syphilis.

MARCH 10. Marcello Malpighi, born March 10, 1628, was the first to study tissues with the

microscope. Malpighi deserves to be known as the founder of histology and descriptive embryology. Biographic studies indicate that he was gentle, gracious and lovable.

MARCH 15. Pierre Curie was born on March 15, 1859. His collaboration as a physicist with his wife Marie, a chemist, and the resulting discovery of radium make a thrilling story which has been popularized by their daughter, Eve.

MARCH 18. Lady Mary Wortley Montague, the first prominent English citizen to sponsor inoculation against smallpox, had her son inoculated on March 18, 1718. Lady Mary learned of inoculation in the Near East, where it was used to preserve the beauty of Circassian girls who were sold into slavery.

MARCH 24. On March 24, 1882, Robert Koch read a paper entitled "Etiology of Tuberculosis" before the Berlin Physiological Society. That paper, so convincing that even the great pathologist Virchow did not venture to discuss it, is recognized today as the foundation upon which rests the modern treatment and prevention of tuberculosis. Koch said, "I came upon regions where gold was still lying by the wayside." Koch's motto was "Never be idle."

MARCH 30. Crawford W. Long first used ether anesthesia on March 30, 1842, in Jackson County, Georgia. Mementoes and evidence of his priority over Morton in ether anesthesia are in the possession of Long's alma mater, the University of Pennsylvania School of Medicine.

Parathion Poisoning

The use of the insecticide parathion (o,o-diethyl o-p-nitrophenyl thiophosphate) increased materially in Florida citrus groves in 1950, and additional increases in its use are anticipated during the 1951 growing season. While complete records were impossible to obtain in 1950, incomplete data suggested that as many as 50 cases of parathion poisoning may have occurred. In addition to these, a number of individuals thought they were poisoned, but careful examination revealed that such was not the case.

Since the parathion spray season is starting in Florida, it seems advisable to emphasize some facts involved. Parathion poisoning is characterized by a reduction of cholinesterase. The most common symptoms noted in 1950 were nausea, general muscular weakness, tightness in the chest, and contracted pupils. Atropine is specific for treatment.

In severe cases oxygen therapy and even artificial respiration are indicated.

Pre-employment examinations have been recommended for men who will handle parathion. Such examinations require at least 5 cc. of heparinized blood and should include blood protein, red blood cell and plasma cholinesterase, and hemoglobin tests. If any of these are found to be below normal, it should be considered as predisposing the individual to parathion poisoning. It is advisable that cholinesterase tests be used as a means of positive diagnosis of parathion poisoning.

Florida Society Of Ophthalmology And Otolaryngology Holds Midwinter Meeting

The fourth midwinter meeting of the Florida Society of Ophthalmology and Otolaryngology was held at the San Souci Hotel in Miami Beach on Jan. 17, 1951. There was a record attendance of approximately 200. In addition to a fair representation of the membership, there were present many distinguished guests from over the nation who were attending the Midwinter Seminar of Ophthalmology and Otolaryngology and the Southern Section of the American Laryngological, Rhinological and Otological Society, meeting concurrently in the same hotel.

When the scientific session convened at 8 p. m., the members and guests were welcomed by Dr. R. Renfro Duke of Tampa, President. The guest speakers were Dr. George Shambaugh of Chicago, whose subject was "The Fenestration Operation," and Dr. Conrad Berens of New York, who spoke on "Experiences with ACTH and Cortisone in Ophthalmology."

During the evening Dr. Heinrich Kobrač's remarkable sound motion picture, entitled "The Inner Ear," was shown.

In accord with the custom of the Society, Dr. Duke presented to Dr. W. Jerome Knauer of Jacksonville, immediate past president, a past president's key.

Prior to the meeting, at the cocktail hour, the Society and the Seminar were joint hosts to the many visiting physicians and their wives.

This midwinter meeting of the Society, held each January in Miami Beach while the Seminar is in session there, should draw a much larger attendance from the membership next year and from year to year as the members come to appreciate more and more the value of the opportunities afforded.

Fifth Midwinter Seminar In Ophthalmology And Otolaryngology

Physicians from 30 states and 3 foreign countries attended the fifth annual Midwinter Seminar in Ophthalmology and Otolaryngology, held in Miami Beach the week of Jan. 15, 1951. Among the 178 registrants were distinguished representatives of the two specialties from various sections of the country. The Seminar, sponsored by the Graduate School of Medicine of the University of Florida, meets each January in Miami Beach and was held this winter in the new San Souci Hotel.

The faculty was chosen from eminent specialists in their respective fields. Lectures on Otolaryngology were presented the first three days by Drs. Louis Clerf, Philadelphia; Gordon Hoople, Syracuse; D. M. Lierle, Iowa City; Benjamin Spector, Boston; and George Shambaugh, Chicago. Famous ophthalmologists lecturing on the last three days were Drs. Conrad Berens, New York; Ramon Castroviejo, New York; Jack Guyton, Baltimore; Harold Scheie, Philadelphia; and Edmund Spaeth, Philadelphia.

This yearly Seminar has deservedly won national recognition and wide acclaim. It affords Florida ophthalmologists and otolaryngologists an unsurpassed opportunity for graduate training within the bounds of their home state.

Crossroads Cancer Seminars Announced

The Florida Division of the American Cancer Society, the Florida State Board of Health, and the Department of Medicine of the Graduate School of the University of Florida announce that Crossroads Cancer Seminars will be held throughout the state in March and April.

The lectures will be given in the northern part of the state early in March and in the middle and southern parts early in April. The schedule of dates and places follows:

- March 6, Tuesday — San Carlos Hotel, Pensacola
- March 7, Wednesday — Health Department Building, Panama City
- March 8, Thursday — Memorial Hospital, Tallahassee
- March 9, Friday — Blanche Hotel, Lake City

April 3, Tuesday — Ocala
April 4, Wednesday — Nurses Educational
Building, Orlando
April 5, Thursday — Sebring Hotel, Se-
bring
April 6, Friday — Fort Myers

The program in each city will begin at 2 p.m. There will be an afternoon and an evening session. The group will meet for dinner if it is the desire of the local medical society. No tuition fee will be charged.

The lectures in the northern part of the state in March will be given by Dr. Sam A. Wilkins, Jr., Associate Professor of Surgery and associated with the Winship Clinic for the treatment of malignant diseases, Emory University School of Medicine, Emory, Ga. The lectures in middle and southern Florida will be delivered in April by Dr. Ralph R. Braund, Professor of Oncology-Surgery, University of Tennessee College of Medicine, Memphis, Tenn., who was formerly of Memorial Hospital, New York City.

This is the second year the Crossroads Cancer Seminars have been offered. This type of graduate education on the subject of cancer is presented this year in supplement to the Seminar held last year in Jacksonville and the year before in Miami. Graduate training of this nature in diverse locations is offered in the hope that every physician will have an opportunity to attend.

T. Z. Cason, M.D., Director,
Department of Medicine
Ashbel C. Williams, M.D., President,
Florida Division, American Cancer Society
Wilson T. Sowder, M.D., State Health Officer

Anniversaries

In this issue of The Journal there appears editorially the second in a series of anniversaries of interest to physicians. It is the purpose of the Editors to continue these historical reminders from month to month throughout the year in the hope that they will offer inspiration, spur incentive and foster pride in a noble profession.

Report of Delegates to A.M.A. Cleveland, Dec. 5-8, 1950

The House of Delegates was called to order at 10:00 a.m. by the Speaker, Dr. F. F. Borzell of Philadelphia. The Credentials Committee reported that of the one hundred ninety-eight eligible delegates, one hundred ninety-five were present. This is a record attendance.

The first order of business was the selection of the General Practitioner of the Year. Three men were nominated by the Board of Trustees: Dr. Jim Camp, Pecos, Texas; Dr. Dean Sherwood Luce, Canton, Massachusetts, and Dr. John William Strange, Loogootee, Indiana. Dr. Luce was elected.

We then heard addresses by the Speaker of the House and by the President, Dr. Elmer L. Henderson. The President's address was in the form of a report and it was brief, concise and factual. His statement regarding the value of our advertising campaign, which marked the first time in the history of the United States that any business, profession or industry under government attack had been successful in rallying nationwide advertising support from thousands of unrelated groups, companies and individuals, was encouraging to the Members of the House. He also called the election results in November "heartening and reassuring." He called for all members of the profession to continue in the good work they had begun.

Practically all of the reports of the various officers and committees of the Association were in the form of progress reports.

Considerable satisfaction was expressed in the substantial expansion of the Washington office and it was particularly commended for the interesting style used in the Bulletin and Capitol Clinic. It has played an important role in reviewing legislation, supplying materials to members of Congress and also arranging for hearings on matters of interest to the medical profession. An interesting observation is that not one single bill opposed by American medicine was passed into law by the 81st Congress.

The Department of Public Relations has shown considerable increase in its activities during the past year, which was made evident by the fact that we had such excellent coverage by the press at the meeting in San Francisco and at the World Medical Association Meeting in New York.

The following recommendations on National Emergency Medical Service were adopted: (1) that each of the state and territorial associations seek adequate representation on Civil Defense Advisory Committees at all levels of government; (2) that the American Medical Association request appointment of an advisory committee of civilian physicians in the new Civil Defense Administration; (3) that a copy of the report of the Council on National Emergency Medical Service be sent to secretaries of state and territorial associations and to the chairman of the Emergency Medical Service Committee in each state; (4) that the two remaining constituent associations without an Emergency Medical Service Committee be urged to appoint such committees without delay (All other constituent associations have such committees, but many are without complete programs); (5) that the Council on National Emergency Medical Service and the Committee on Blood Banks have some appropriate space in *The Journal of the American Medical Association*, so that information regarding the actions and recommendations of their respective committees be brought to the attention of our members and the various Emergency Medical Service Committees as promptly as possible.

In formulating any plan for emergency medical service, consideration should be given to several factors: (1) Economical use of medical manpower by establishing and maintaining a proper balance between military and civilian needs; (2) Provision for rotation of doctors in the armed services so as to equalize the burden on individuals and disrupt as little as possible the teaching faculties and thus allow for a continuous progression of trained specialists and practitioners into the active professions; (3) Flow of properly trained students into the medical schools continued at the present or a higher level; (4) Postgraduate instruction maintained or increased so as to provide the number of doctors required not only in the specialties but in general practice.

The Board of Trustees appointed a Committee to confer with the Board of Regents of the American College of Surgeons, representatives of the American Hospital Association and the American College of Physicians with the view of arriving at a satisfactory solution to the problem of hospital standardization. At the last meeting of the joint committee it was suggested to establish a joint commission on hospital standardization to be composed of eighteen members representing the four

organizations. A rough draft of a proposed constitution and by-laws was then prepared and a copy of it has just been given to the Board of Trustees for study. Negotiations are still going on and much progress has been made and every effort is being made to reach satisfactory arrangements on this important question.

The House of Delegates has endorsed the idea of a national blood procurement program under the auspices of the American National Red Cross. As problems have arisen, the Red Cross has at different times expressed a desire to solve them and has made specific agreements with the American Medical Association. In these agreements the Red Cross accepted liaison with the American Medical Association through the Committee on Blood Banks. It has been agreed that, to insure safety to recipients, the responsibility for technical details must rest on properly trained personnel under the control of local or state medical societies, and that local control must be exercised by the county medical society, which should be the initial contact in the contemplation of inauguration of a new blood bank. No publicity or news releases are to be issued except by mutual consent of the local county medical society and the local chapter of the Red Cross. Differences of opinion in establishment or operation of a blood bank in either administrative or technical detail are to be arbitrated at state levels by joint committees from the state medical society and the Red Cross. It has been generally agreed that the principle of blood replacement by the patient, his family, his friends or his organizations is sound, and inter-bank exchange of blood on a unit for unit basis should be encouraged.

On July 11 and 12, 1950, at a meeting in Boston of the Committee on Blood and Blood Derivatives of the Red Cross, together with its Medical Advisory Committee on the National Blood Program, there were present, by invitation, representatives of the American Medical Association, the American Hospital Association and the American Association of Blood Banks. The following agreement, drawn up at this meeting, sets forth the relation among these four organizations in peacetime and in the event of a national emergency:

Representatives of the American Medical Association, American National Red Cross, American Association of Blood Banks and the American Hospital Association have been meeting to aid in the development of the best possible blood transfusion service for physicians, hospitals and patients who use the blood—in fact, in the interest of national unity throughout the country. After carefully

considering the information available, these representatives declared that it seemed advisable to co-operate with the National Security Resources Board by, in time of peace, providing for free exchange of blood between the Red Cross Regional Blood Centers and blood banks operating under other auspices on a unit for unit basis whenever and wherever it is needed to serve to the best advantage the interest of the community. It seems advisable for such units to be the property of the recipient blood bank, to be used in accordance with its usual policy of issuing blood. As a principle, the groups favor making surplus blood available to the Red Cross or other agencies processing blood for the purpose of converting it into derivatives for the benefit of the people. By "surplus blood" is meant all blood that is not required for use as whole blood, plasma or any other derivative by the blood bank concerned.

In the event of a disaster or a national emergency, the Red Cross, the American Medical Association, the American Hospital Association and the American Association of Blood Banks favor in those communities not served by a Red Cross Regional Blood Center, the establishment of such a center and/or the use of existing blood bank facilities to procure the necessary amount of blood. The method to be used should be determined in a manner which meets the approval of the county medical society and the local blood banks and hospitals. Furthermore, the operation of the local blood bank facilities for civilian need should not be interfered with by the emergency program so far as consistent with government regulations existing at that time.

There is definitely a need for the use of standardized equipment and methods for the procurement and dispensing of blood; this is imperative in a national emergency and desirable in time of peace. To insure minimum standards, all blood banks cooperating in such a procurement program, should meet the minimum standards of the National Institutes of Health.

The Committee on Blood Banks heartily approves the agreement reached in Boston and has been notified of approval by the Board of Trustees. The Committee recognizes that the modus operandi of this agreement will necessitate many adjustments to meet local conditions. From time to time the Committee will report to the Board of Trustees plans for implementation of this agreement with the recommendation that they be published. At an early date the Red Cross will request the cooperation of a number of cities in the procurement of blood. When a community is thus selected, the professional groups interested will be invited to work out a program of procurement most suitable for that particular community. This group will include the local Red Cross chapter, the county medical society, local hospitals, local blood banks, if any, and probably the local public health officer.

The Red Cross has been designated by the Secretary of Defense as the official procurement agency for blood and blood derivatives for the needs of the Armed Forces, and the National Security Resources Board has similarly designated

the Red Cross "to accept the responsibility of coordinating a nationwide civil defense blood program for recruitment of donors and collecting, storing, processing, and preparing for shipment of blood and blood derivatives."

All federal agencies designating the Red Cross in blood procurement will charge this organization with the responsibility not only of blood procurement but also of securing necessary correlation and cooperation of other agencies interested in blood procurement. The Department of Defense expects to reimburse the Red Cross for actual costs incurred in procurement of blood and blood derivatives for the Armed Forces.

In its study of the blood bank resources of the United States and possessions, the Bureau of Medical Economic Research of the American Medical Association has found that the 34 regional centers of the Red Cross issue less than 15 per cent of the blood used as whole blood. The rest is issued by hospital and nonhospital blood banks. Hence the Red Cross must rely on the cooperation of the other blood banks which are currently procuring most of the blood. The Red Cross believes it can double its output with present centers and equipment.

The Committee on Blood Banks is of the opinion that a large scale emergency blood program, whether regional or national, can be successful only if the Red Cross has the willing and wholehearted cooperation of all other agencies in the blood procurement field. It believes that other blood banks can procure emergency blood under the special motivation that would exist and channel it through the Red Cross to the official agencies for which it procures. Joint efforts in the regional, state and local levels are indispensable.

The Committee and the Red Cross agreed that the Red Cross encourage its local chapters, on request of a blood bank cooperating in the emergency program, to assist in the procurement of donors for the cooperating blood banks; that, in event of local disaster, blood requisitioned from local blood banks by the Red Cross be entered as a credit to that bank as an interbank exchange, and that the American Medical Association offer its wholehearted cooperation in the National Emergency Blood Program and encourage other interested organizations to offer theirs.

After consultation with various advisors, the Committee on Blood Banks concluded that mass typing of the general population is costly and inadvisable for technical reasons, including that of

hazards to the patient introduced by dependence on such typing. Previous experiences in mass typing have been disturbing rather than reassuring. On the advice of federal officials, the committee stressed the importance of increasing the production of blood substitutes as well as whole blood in the present emergency.

The Committee desires to emphasize that at this time the national emergency blood program is and must continue to be a three-pronged activity, each part of which must be developed to keep the whole program in balance. These three parts are (1) the maintenance of supplies of blood and plasma for normal civilian requirements, (2) the furnishing of whole blood and plasma to the Armed Forces of the United States, and (3) the development of dispersed reserve supplies of equipment for collecting blood and dispersed reserve supplies of blood plasma for civilian defense.

The Red Cross has been exerting continuous pressure on all of its regional blood centers by increasing their quotas of blood procurement for military emergency needs. While these regional centers will very shortly be procuring much more blood than the stepped up quotas they are now meeting, the Red Cross will continue to rely on the participation of all other blood procuring agencies in the national emergency blood program.

At a meeting of all participating organizations held in Washington in September, it was agreed that the Red Cross should set up in various cities in the United States special defense blood collection centers, and that in the cities so designated local committees of all participating organizations would determine what, in the opinion of the local committee, was the best method of collecting blood in its city. The Committee re-emphasized its previous recommendation that full credit be given in publicity at the local level to all participating organizations and that this recommendation be called to the attention of the new president of the Red Cross.

Under the national emergency blood program contractual relationships have been established with all companies equipped to process blood into dried plasma and serum albumen. The capacity of these plants is being expanded and during 1951 the blood requirement will probably strain the facilities and personnel of all existing blood banks in the United States. The first shipment of whole blood to Korea was made on Aug. 25, 1950, and many shipments of type "O" blood have been

made since. These have been made possible through the increased quotas of Red Cross regional blood centers and through the active participation of many other blood banks, particularly of those located on the West Coast.

The pattern of cooperation in the blood program will vary according to local conditions in the several states. The Committee recommends that, in order to avoid duplication and overlapping of effort and the confusion resulting therefrom, each state medical society see to it that a state committee on blood banks be established, whose function it would be to correlate the elements of the emergency blood program in its state and to see that the blood procured is properly channeled. These committees should include representation from hospitals, blood banks and the Red Cross.

The American Medical Association has been asked whether it would modify its stand on federal aid to medical education for the period of the emergency. The following points should be borne in mind:

1. All medical schools are at present operating at or nearly at capacity. Enrolment in medical schools is at an all time high.
2. Any further increase in enrolment can be accomplished only in one of two ways: (a) by increasing physical facilities and teaching personnel or, (b) by decreasing standards in medical education.
3. Even if increased enrolment were now possible, it would be four years before any additional doctors could graduate. To increase enrolment by increasing physical facilities would require considerably longer than the four years above mentioned.
4. Therefore, it is doubtful if the emergency can be helped no matter what procedure is adopted and the problem should be considered rather from its long range aspect.

The attitude of the American Medical Association on federal aid to medical education has been misconstrued and often deliberately so.

The American Medical Association would not oppose federal aid to medical education if it could be assured of two things: First, that any legislation would guarantee absolute freedom of medical education from governmental control; second, that all sources of private support for medical education have been exhausted. Up to the present, neither of these is assured.

The American Medical Association recognizes that some medical schools are now in financial difficulties, and in view of the national emergency may face greater ones. The extent of these financial difficulties has not been made clear. Recognizing the greater need for financial assistance to

medical schools beyond what they are now receiving, the American Medical Association nevertheless believes that further efforts should be made to obtain these funds from private sources. Furthermore, the Association is willing to lend its support to a campaign for raising funds for medical education among the professions, industry and labor. It urges that such an all out drive be started immediately.

Dr. Louis H. Bauer, Chairman, Board of Trustees, announced to the House of Delegates that it had appropriated one-half million dollars out of its National Education Campaign fund, which was raised to defend medical freedom, for the aid and support of medical schools which are in need of additional funds. There is a growing public awareness that further subsidy has come to be a burden, not a bounty, for it is bringing intolerable increases in taxation and is dangerously increasing federal controls over our institutions and the lives of our people. American medicine feels very strongly that it should not seek federal aid for medical schools until all other means of financing have been exhausted. The Board of Trustees announced its belief that funds for this purpose could be obtained from private sources and as practical evidence of our sincerity of purpose this appropriation has been made as the nucleus of a fund which we hope will be greatly augmented by many other sources. The Board hopes that this action will become a stimulus to other professions, industry, businesses, labor groups and private donors to contribute to this very important cause of protecting and advancing the interest of medical education and in the public health.

The Board of Trustees asked an expression from the House of Delegates relative to whether or not the clinical session should be continued. At the meeting in November 1948 in St. Louis, over 2,200 doctors registered and at the 1949 meeting in Washington, there were 3,942 registered. At this last meeting of the clinical session in Cleveland there were 2,100 doctors registered but it must be remembered that this was just a week following a very severe snow storm and blizzard in that area. The House of Delegates took the following action in regards to the clinical session. Article II of the Constitution of the American Medical Association states "the objects of the association are to promote the science and art of medicine and the betterment of public health." We feel in view of this, and after noting results

of the surveys made following the various clinical sessions, that the clinical sessions should be continued. The 1951 clinical session will be held in Houston, Texas, the 1952 session in Denver and the 1953 session in St. Louis.

Respectfully submitted,
Homer L. Pearson, Jr.
Louis M. Orr, II

YOUR BLUE SHIELD

Out-of-State Blue Shield Patients

In order that the participating physician may receive immediate action on Blue Shield Doctor's Service Reports submitted for services rendered members of Blue Shield plans outside the State of Florida, it is necessary that the Doctor's Service Report be mailed directly to the plan to which the patient belongs.

The Blue Cross Inter-Plan Service Benefit Bank, under which out-of-state Blue Cross members may receive benefits through the local plan, in no way includes Blue Shield services rendered by participating physicians. This is a Blue Cross service only. A similar Blue Shield service has not as yet been established.

If the subscriber's identification card or contract indicates that he is a member of an out-of-state Blue Shield Plan, the forms of the Florida Blue Shield Plan may be used to initiate the claim with the subscriber's plan. Because of the similarity of information required by all Blue Shield Plans, it is not usually necessary that the forms of the out-of-state plan be used.

Many of your out-of-state Blue Shield patients may not know that Blue Shield cases must be handled directly with their home plans, even though Blue Cross benefits are available through the local plan under the Inter-Plan Bank. This fact should be pointed out to your out-of-state Blue Shield patients to avoid misunderstanding.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Morris A. Price of Jacksonville announce the birth of a daughter, Donna Sue, on Jan. 9, 1951.

Dr. and Mrs. Sullivan G. Bedell of Jacksonville announce the birth of a daughter, Mary Elizabeth, on Jan. 20, 1951.

Deaths—Members

Nave, Dick D., Weston, W. Va.	Dec. 26, 1950
Butler, Paul T., Orlando	Jan. 4, 1951
Rickard, Elsmere R., Tampa	Jan. 16, 1951

Deaths — Other Doctors

Slocumb, Clyde B., Doerun, Ga.	Oct. 29, 1950
Puffer, Maurice L., Downers Grove, Ill.	Dec. 29, 1950

STATE NEWS ITEMS

President Herbert E. White called a joint meeting of certain groups for January 28, 1951 at 10:00 a.m. in the Marion Hotel in Ocala.

This joint meeting was in accordance with an action of the House of Delegates, April 1950, which designated the inclusion of the Board of Governors, members of the House of Delegates, Bureau of Public Relations and the Association's Committee on Legislation and Public Policy. These conferences must be held sixty days prior to the convening of the state legislature (June 1950 Journal, page 756). The purpose of such bi-annual conferences is for the discussion of bills that may be introduced during the legislative session.

At the Ocala conference there was an attendance of 66. In the following list of names of those who were present, it will be noted that the groups are listed in the order in which they were designated by the action of the House of Delegates. The names in each group are listed as shown on the Officers and Committee list in your Journal and the delegates as listed in the order shown in the June 1950 Journal, pages 750 and 752. Duplicate names will be noted in the list; for example, if a doctor is a member of the Board of Governors and also a delegate, his name will be shown in both places.

REGISTRATION — TOTAL 66

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DELEGATES

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OTHERS GUESTS

Messrs. Fred M. Burns, James Messer, Ben C. Willis, M. H. Doss, H. A. Schroder, Ernest R. Gibson.

Dr. Sherman B. Forbes of Tampa has recently been appointed a Consultant to the National Society for the Prevention of Blindness.

The Southern Section of the American Laryngological, Rhinological and Otolological Society met at the San Souci Hotel in Miami Beach on January 17, 1951, during the week the Midwinter Seminar in Ophthalmology and Otolaryngology was being held there. Dr. Charles C. Grace of St. Augustine is the chairman of this group.

Dr. John W. Williams of Lakeland is co-author of a chapter recently published in the Oxford Loose-leaf Medicine, entitled "Tetanus and Gas Gangrene."

Dr. Reuben B. Chrisman, Jr., of Miami has been invited to speak at the centennial meeting of the Kentucky Medical Association to be held in Louisville, October 2-4.

Dr. Kenneth A. Morris of Jacksonville has been elected chairman of the Duval County Welfare Board and Dr. Walker Stamps has been appointed to a special committee of this board.

Dr. John H. Mitchell of Jacksonville retired recently as president of the Board of Trustees of the local Baptist Home for Children, after having served in this capacity for fourteen years. He will continue as a member of the Board of Trustees.

Dr. Bernard J. McCloskey of Jacksonville was recently elected chairman of the Duval County Unit of the American Cancer Society. Other members of the executive committee include Drs. A. Judson Graves, Ferdinand Richards, Lauren M. Sompayrac, Wilbur C. Sumner and Ashbel C. Williams.

Dr. Gary E. Turner of Jacksonville was the guest speaker at the January meeting of the Parent-Teachers Association of the Lola M. Culver School.

Dr. Robert J. Needles of St. Petersburg has been elected president of the St. Petersburg Heart Association. Dr. Norval M. Marr, also of St. Petersburg, is a member of the board of directors.

Dr. Kenneth Dunham of Frostproof recently addressed the local Rotary Club on newly-developed drugs.

Dr. William J. Phelan of Jacksonville was one of the speakers at a January meeting dealing with the blood procurement program and its relation to civil defense. The program was arranged by Dr. Robert B. McIver, president of the Jacksonville Blood Bank.

Dr. Jabe A. Breland of Marianna was the guest speaker on January 22 at a meeting of the Brotherhood of the First Baptist Church in Bonifay.

Dr. Russel L. Counts has opened offices for the practice of medicine in Jasper.

The second annual Medical Seminar of the Sarasota County Medical Society will be held March 19-24 at 8:00 p.m. in Sarasota. Speakers will be provided by the Johns Hopkins University School of Medicine and will include the following: Dr. Houston Everett, "Female Urology," Dr. Emil Novak, "Gynecology and Endocrinology," Edward Stafford, "Surgery," and Dr. Ward B. Allen, "Medicine."

All Florida doctors are invited to attend any or all meetings. There will be no registration fee.

Dr. Wm. W. McKibben of Miami recently gave a talk to the Republican Club of Greater Miami on deaths and injuries due to hurricanes.

Dr. Camillus S. L'Engle of Jacksonville has returned to his practice following a special training course at the New York Hospital, operated as a part of the Cornell University Medical College. The course was one designed to help preserve the lives of babies born prematurely.

Dr. Kenneth G. Gould of Tampa recently addressed the Tarpon Springs Rotary Club on the subject, "Be Your Age." Dr. Gould also presented a motion picture film entitled "Men After Forty."

Dr. Sanford Levine of Miami Beach has been awarded a certificate of appreciation by the Third Army for his outstanding service in the past three and one-half years.

Dr. Ashbel C. Williams of Jacksonville was guest speaker at the local Cavalette Club on January 11. Dr. Williams spoke on cancer and following his talk led a question and answer period on this subject.

Dr. Walter B. Tomlinson of Warrington was the guest speaker at the December meeting of the Nutrition Council of Escambia County.

Dr. M. Eldridge Black of Clearwater recently spoke to the local Rotary Club on the need for expansion at Morton Plant Hospital.

Dr. Joseph S. Stewart of Miami was toastmaster at the annual author's night of the Miami Bookfellows.

Dr. Julius C. Davis, Quincy, state councilor of the Southeastern Surgical Congress, has announced the nineteenth annual meeting of the Graduate Assembly of the Congress, April 11-14, 1951, at the Hollywood Beach Hotel, Hollywood, Florida.

Drs. Ashbel C. Williams of Jacksonville and Frank M. Woods of Miami are listed among the outstanding guest speakers for the four-day meeting. For additional information, contact Dr. B. T. Beasley, 701 Hurt Building, Atlanta 3, Georgia.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bailey, Charles D., Orlando
 Bartley, Henry E., (Col.), Daytona Beach
 Cheleden, John J., Ocala
 Deen, Oliver F., Jr., Tampa
 Fernandez, Celestino G., Tampa
 Gernon, William, Lake Worth
 Hamerick, George, Jr., Ft. Lauderdale
 Hoare, Francis C., Clearwater
 Hopkins, George D., II., St. Petersburg
 Howard, Everett E., Gainesville
 Hughes, Lawrence M., New Smyrna Beach
 Johnson, Ernest C., Jr., Pahokee
 Kokomoor, Marvin L., Gainesville
 Koontz, E. Ransom, St. Petersburg
 Liddy, Frank J., Arcadia
 Lindeman, Frank H., Jr., Tampa
 McChesney, William W., Gainesville
 Mehl, Omar C., Tampa
 Meldrum, Thomas W., Cocoa
 Myers, Rex E., Jr., Tampa
 Schaber, Jack F., Eustis
 Schanck, George P., Jr., (Col.), Orlando
 Shekter, Abraham J., Hollywood
 Smith, B. Arthur, Ormond Beach
 Stevens, Ernest J., Orlando
 Storey, Wray D., Tampa
 Streets, Benjamin F., Pinellas Park
 Wolfe, Charles J., Daytona Beach

COMPONENT SOCIETY NOTES

Broward

The Broward County Medical Society is expanding its public relations program to join with the Dade County Medical Association in participation in the "Tell Me, Doctor" series being broadcast from Radio Station WQAM, Miami. Dr. Raymond M. Price of Ft. Lauderdale is chairman of the Broward Public Relations Committee.

The "Tell Me, Doctor" program consists of five minute health talks which are recorded by the physicians and broadcast at a later time.

Dade

Guest speaker for the February meeting of the Dade County Medical Association was Dr. Arthur J. Geiger, Associate Clinical Professor of Medicine in Cardiology, Yale University School of Medicine, who spoke on the subject, "Interrelationship Between Gastrointestinal and Cardiac Disorders."

The county association is again sponsoring the Association of American Physicians and Surgeons essay contest and will award three local cash prizes.

Duval

The Duval County Medical Society, at its regular February meeting, included on its program a seminar on "The Surgical Emergency," and a motion picture, "Self-Examination of the Female Breast." The county society has approved local participation in the national Association of American Physicians and Surgeons essay contest and will award local prizes.

Indian River

All members of the Indian River County Medical Society have paid their 1951 state dues.

Marion

At the regular monthly meeting of the Marion County Medical Society on January 16, Dr. James B. Glanton and Dr. Joseph C. Hayward of Orlando gave illustrated talks on pediatric urology. Members present were: Drs. William H. Anderson, Jr., Hugh H. Barfield, John J. Cheleden, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, Eaton G. Lindner, John D. Lindner, Carl S. Lytle, William J. McGovern, John N. Moore, Robbins Nettles, Eugene G. Peek, Sr., Eugene G. Peek, Jr., Robert E. Thompson and Thos. H. Wallis, Ocala; Clifford E. Vinson, Williston, and Herbert M. Webb, Jr., Wildwood. Dr. C. Ashley Bird of Jacksonville was a guest.

Pinellas

The Pinellas County Medical Society, at its regular January meeting, approved an appropriation of \$175.00 for local prizes for the 1951 Association of American Physicians and Surgeons essay contest, which is again being sponsored by the state association.

The scientific session of the regular meeting on February 5 included a symposium on tuberculosis.



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—Editorial: Dramamine,
GP 2:27 (July) 1950



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*Hill, L. W.: New England J. Med. 242:288, 1950

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MRS. NELSON A. MURRAY, Newsletter.....*Jacksonville*
MRS. RALPH S. SAPPENFIELD, Hospitality.....*Miami*

What Every Doctor Should Know

In April, the annual meeting of the Florida Medical Association will be held in Hollywood. At the same time, the Woman's Auxiliary to the Florida Medical Association has scheduled its annual meeting. This double-header is a must for all those interested in how Florida doctors and their wives correlate their efforts in one phase of medical activity.

To all doctors, whose wives would prefer being contributors toward their efforts rather than companion pieces who drift restlessly and unacquainted among strangers while the husbands attend their sessions, or who stay at home because they do not understand that they are welcome, I suggest that they urge their wives to attend the Auxiliary sessions, become acquainted and find out what other doctors' wives are doing.

Remember, we are a group organized primarily to cultivate friendly relations and promote mutual understanding among physicians' families. Our function as a group is to participate in any endeavor at the request of the Florida Medical Association.

We feel that those who by-pass these meetings are unacquainted with the purpose of them rather than that they reject the principles which motivate them; that is why we extend this invitation to the doctors' wives. Friendliness, however, cannot be coerced; we can only invite friendship, it must be a reciprocal feeling to develop.

Mrs. C. Robert DeArmas
President-elect

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting March 19, April 2, April 16. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, April 2, April 30, June 4. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 19, April 16, May 14. Surgery of Colon & Rectum, One Week, starting April 9, May 14. Basic Principles in General Surgery, Two Weeks, starting April 2. Fractures & Traumatic Surgery, Two Weeks, starting June 18.

GYNECOLOGY—Intensive Course, Two Weeks, starting March 19, April 16. Vaginal Approach to Pelvic Surgery, One Week, starting April 2, May 7.

OBSTETRICS—Intensive Course, Two Weeks, starting April 2, June 4.

MEDICINE—Intensive General Course, Two Weeks, starting April 23. Gastroenterology, Two Weeks, starting May 14. Gastroscopy, Two Weeks, starting May 14. Electrocardiography & Heart Disease, Two Weeks, starting March 19.

PEDIATRICS—Intensive Course, Two Weeks, starting April 2. Congenital & Acquired Heart Disease in Children, Two Weeks, starting May 7. Cerebral Palsy, Two Weeks, starting July 9.

UROLOGY—Intensive Course, Two Weeks, starting April 16. Cystoscopy, Ten Day Practical Course, every two weeks.

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Never before has a surgical unit of such performance been offered at the low price of the Blendtome.

Write "Blendtome Folder" on your prescription blank or clip your letter head to this advertisement. Reprint of electrosurgical technic mailed free on request. Please indicate your specialty.

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Please send me, by return mail, free brochure on the portable Blendtome Electrosurgical Unit.

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THE TECHNICAL EXHIBIT

One feature that always adds materially to the success of an annual meeting is the technical exhibit. Every firm represented in the display features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

LEDERLE LABORATORIES DIVISION — 1

You are cordially invited to visit our exhibit booth where you will find representatives who are prepared to give you the latest information about Lederle products.

WESTINGHOUSE X-RAY DIVISION — 2**H. G. FISCHER & COMPANY — 3**

Inspect H. G. Fischer & Co.'s modern, efficient, low priced x-ray and physical therapy equipment. Let them point out many features of advantage in these representative units and other models not on display, also explain their extremely liberal terms of sale. Your visit welcome — no obligation.

SEALY, INCORPORATED — 4-5**G. D. SEARLE & CO. — 6****THE NATIONAL DRUG COMPANY — 9**

You are cordially invited to attend the booth of The National Drug Company. Our display will feature Benat Drops, Benat with B-12 Tablets and Benat with B-12 Injectosol. Also featured will be Resinat and AVC Improved Vaginal Cream. Many other outstanding preparations of The National Drug Company will be displayed and representatives will be in attendance to discuss all these products with physicians.

KELEKET X-RAY OF FLORIDA — 10**TABLEROCK LABORATORIES — 11**

Mr. Harry T. Brown, our professional service representative, will be in attendance to explain the merits of our prescription specialties, which will be on display at all times.

C. B. FLEET CO. — 12

C. F. Fleet Company, Inc., cordially invites you to stop by their booth for a short visit with Bill Avery, the representative who sees you in your office about once a year. Perhaps there is something about Phospho-Soda (Fleet), the pure, stable, aqueous concentrate of the two U. S. P. Sodium Phosphates, you would like to discuss with him.

THE COCA-COLA COMPANY — 13-14**BURROUGHS-WELLCOME & CO., INC. — 15**

Intermediate-acting Globin Insulin (B. W. & Co.) will be a feature product. Globin Insulin, a clear solution which requires no preliminary shaking, is now official in the U.S.P.—the only intermediate-acting insulin to receive this recognition. Also featured will be Perazil brand chlorcyclizine hydrochloride, the chemically different antihistaminic distinguished by its long action and low incidence of side-effects; and Empiral, which combines the well-known analgesic action of Tabloid Empirin Compound with the sedative action of phenobarbital.

THE UPJOHN COMPANY — 16

The Upjohn exhibit will present the anticoagulant family: Heparin, Depo-Heparin, and Dicumarol, with particular emphasis placed upon Depo-Heparin. When heparin is prepared in a gelatin vehicle (Depo-Heparin) and administered intramuscularly, markedly prolonged effects are obtained. A single injection of 1 cc. (200 mg.) of Depo-Heparin will prolong the blood coagulation time for about twenty-four hours.

THE NESTLÉ CO., INC. — 18

The Nestlé Company, Inc., cordially invites you to visit their exhibit where specially qualified representatives will be on hand to answer your questions on any of Nestlé's milk products—already best known and most used for babies 'round the world.

E. R. SQUIBB & SONS — 19

E. R. Squibb & Sons look forward to seeing you at the Florida Medical Association meeting. In support of the active scientific program which has been arranged, you will find the Squibb representative glad to discuss all relative products. Also, for your convenience, selected professional leaflets will be available which you may take or request us to mail to your home. Please visit the Squibb booth.

PICKER X-RAY CORP. — 20

PROFESSIONAL INSURANCE CORP. — 21

CAMEL CIGARETTES — 22

Camel Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking Camel Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking Camels."

WINTHROP-STEARNES, INC. — 23

AMERICAN OPTICAL COMPANY — 24

The American Optical Company will present an exhibit of some of their later developments of "Scientific" and "Ophthalmic" instruments and equipment. All members and guests of the Florida Medical Association are cordially invited to visit this booth for explanations and demonstrations by trained instrument representatives of the American Optical Company.

CHAS. PFIZER & CO., INC. — 25

PET MILK COMPANY — 26

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

SURGICAL EQUIPMENT CO. — 27-28

Surgical Equipment Company of Miami, will exhibit the latest of surgical equipment and instruments including direct writing electrocardiographs and Profexray new type model office X-Ray. We extend a cordial invitation to all physicians to visit our booth, see our display and demonstrations.

PARCO SURGICAL SUPPLIES — 29

A cordial invitation is extended to you to visit our booth to see some of the latest aids for the profession including the new Edin Vasculator.

Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally^{1,2} stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance.^{1,2} Such states may involve any one of the organ systems or several at one time.^{1,3} The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references^{3,4,5,6,7}, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives.^{8,9,10}

1. Ebaugh, F.: Postgrad. Med. 4: 208, 1948. 2. Wilbur, D.: J.A.M.A. 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. 42: 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. 27: 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. 107: 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. 58: 251, 1948.

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Registered, American Medical Association

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WHITE LABORATORIES, INC. — 30

White Laboratories, Inc., will have an interesting and unusual display — the latest products of White's research. Courteous Medical Service Representatives in attendance will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of these and other White's products. You are cordially invited to visit this booth.

ABBOTT LABORATORIES — 31

Abbott will exhibit a number of outstanding products, such as Abbotcillin-DC, 600,000 units of penicillin in a 1-cc. cartridge; Sucaryl Sodium, a heat-stable, noncaloric sweetener; Dayalets multiple vitamin tablets with synthetic vitamin A; Truozine Dulcet Tablets, candylike medication containing sulfadiazine, sulfamerazine and sulfamethazine, and Di-Paralene Hydrochloride, a long-acting antihistaminic.

A. S. ALOE COMPANY — 32

Visit our booth where the Aloe representatives will show you a cross section of the complete stock of physicians' equipment and supplies carried by the A. S. Aloe Co. Highlighted will be New Molel Steeline — Tomorrow's Treatment Room Furniture Today — Featuring the Body contour Table Top, Magnetic Door Catches, and Advanced Design, all in New Decorators' Colors.

SCHERING CORPORATION — 33

Featured at the Schering booth will be Schering hormones including Oreton, Proluton and Pranone, the orally effective form of the corpus luteum hormone. Chlor-Trimeton Tablets and Chlor-Trimeton Syrup will also be featured along with Trimeton Lotion and Trimeton Ointment. Neo-Iopax, one of the most dependable and best tolerated urographic contrast media will highlight the exhibit along with Priodax.

MEAD JOHNSON & COMPANY — 34

Dextri-Maltose, Oleum Percomorphum, Pabulum, Pabena, Olac and other Mead Products used in Infant Nutrition will be on display at the Mead Johnson Exhibit at your Florida Medical Association Meeting. Protenum, a new high protein product, will be displayed. Also Lonalac, for low sodium diets. Our representatives at the Exhibit will be glad to discuss with you the new improvements of Amigen and Amisets.

ORTHO PHARMACEUTICAL CORP. — 35

Ortho cordially invites you to their booth. The entire line of Ortho gynecic pharmaceuticals will be featured including the Ortho Kit and other new obstetrical and gynecological specialties.

HOFFMAN-LAROCHE, INC. — 36

Do you know why so many physicians and surgeons are talking about Gantrisin, the safer, single soluble sulfonamide? Have you seen the illustrations showing that Gantrisin's higher solubility obviates renal blocking . . . or the clinical evidence of Gantrisin's wider antibacterial spectrum in systemic and urinary infections? Representatives at the Roche booth will be pleased to discuss with you any questions you may have concerning Gantrisin or other Roche products. Clinical reports, descriptive literature and samples are available for your inspection and use.

THE WM. S. MERRELL COMPANY — 39

Bentyl Hydrochloride is a high milligram potency non-narcotic antispasmodic with two-fold musculotropic and neurotropic action. It is effective therapeutically without central nervous stimulation, or atropine-like side effects.

AMEDIC SURGICAL COMPANY — 40

WALKER VITAMIN PRODUCTS, INC. — 41

Adcets provides Vitamins A, D and C in unique candy-like form for youngsters. The small orange spheres are delightful to chew and have a most pleasing orange flavor. Each dose delivers 5,000 Units of Vitamin A palmitate, 1,000 Units of natural Vitamin D and 50 mg. of Ascorbic Acid, thereby representing the three most important routine supplements required by patients in this age group. A companion product Vadcon offers the same formula in liquid form for administration in drop doses to infants. In addition to these products, the original breath and body deodorant tablet, Olodex will be featured along with Precalcin and other well known Walker ethical specialties.

WYETH, INCORPORATED — 42

Wydate—highly purified hyaluronidase and Tubex—Wyeth's unique, outstandingly convenient form of injectible pharmaceutical preparations, will be featured along with such widely prescribed ethical specialties as S-M-A, Purodigin, Sopronol, Kaomagma, Wycillin, Lentopen, Phosphaljel, Petrogalar, Conestron, Propion Gel and Propion Ophthalmic. Trained representatives will be on hand to supply literature and samples of many outstanding therapeutic agents.

CIBA PHARMACEUTICAL PRODUCTS, INC. — 43

Ciba Pharmaceutical Products, Inc., Summit, New Jersey, invites you to visit its exhibit which features Priscoline (formerly known as Priscol), a valuable adjunct to the treatment of peripheral vascular disease. Pyribenzamine, HCl, the antihistaminic drug for prevention and relief of anaphylaxis and many forms of allergy will also be featured. Representatives in attendance will gladly answer any questions about these and other Ciba products.

THE BORDEN COMPANY — 44

Borden representatives will be more than pleased to discuss a new powdered infant food with you. Bremil is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted in order to supply the nutritional requirements of infants deprived of human milk. Also exhibited will be Mull-Soy, Dryco, Biolac and other prescription products.

ANDERSON SURGICAL SUPPLY COMPANY — 45

GENERAL ELECTRIC X-RAY CORP. — 46

SHARP & DOHME, INC. — 47

Clinical data from the laboratories of the Medical Research Division of Sharp & Dohme are featured in our booth. The potentiating effect of a combination of the antibiotics, bacitracin and tyrothricin; the synergistic effect of penicillin in conjunction with the sulfonamides; and the use of Blood Group Specific Substances A and B in conditioning Group O blood, are of major interest.

SANDOZ PHARMACEUTICALS — 48

It is with a great deal of pleasure and pride that we invite you to visit our Scientific Exhibit on Vascular Headaches. Mr. Louis Begin, our Southeastern Regional Manager and Mr. Elbert McLaury, our Florida representative, will gladly welcome you.

M & R DIETETIC LABORATORIES — 49

Our representatives for Similac and Cerevim will appreciate the opportunity to discuss with you the merits and use of our products in the field of infant and child nutrition.

WANTED — FOR SALE

Advertising rates for this column are \$5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Young physician to reopen office and do general practice at Woodbine, Camden County, Georgia, between Brunswick and Jacksonville. Excellent location, building fully equipped and with living quarters available. Owner away to specialize in surgery. Write 69-44, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: General Practice and fully equipped office, new 20-MA X-ray-Fluoroscope, EKG, BMR, Diathermy. Leaving to specialize, available immediately. Asking \$10,000. Terms. Vitol S. Shepard, M.D., 960 42nd Street, West Palm Beach, Fla.

FOR SALE: Buildings and fifteen acres of grounds suitable for Sanatorium, convalescent center or invalid retreat. Exceptional location at interesting price. Within 90 miles of St. Petersburg, Tampa, Sarasota and Orlando. Box 194, Brooksville, Fla.

ASSOCIATION WANTED: Internist completing formal training for requirements by Board of Internal Medicine on July 1, 1951, desires association with individual or group. Age 28, Navy veteran, Florida license. Write 69-47, P. O. Box 1018, Jacksonville, Fla.

ASSOCIATION WANTED: Board eligible ophthalmologist, good surgical training, grade A medical school, age 32, veteran, desires association with established ophthalmologist, group, or part time affiliation with public institution. Write 69-46, P. O. Box 1018, Jacksonville, Fla.



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HOLLAND-RANTOS COMPANY, INC. — 50

Ask H-R representatives: (1) why it is to your advantage and that of patients to specify Koromex Diaphragms, Jelly and Cream for dependable conception control; (2) why Nylmerate Jelly is so effective in treatment of vaginal trichomoniasis and moniliasis; (3) what other H-R products would be useful in your practice.

MEDICAL SUPPLY COMPANY — 51-52

ELI LILLY AND COMPANY — 53

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit. Many new therapeutic developments will be featured and literature on these products will be available. Visiting physicians will be aided in every way possible.

MEDCO PRODUCTS COMPANY — 54

Your meeting is one of more than 60 state, sectional and national meetings where more than 90,000 physicians in 1951 will have an opportunity to see the very interesting Medcotronic low volt generator. Make it a point to visit our booth where our representative will be glad to demonstrate the Council Accepted Medcotronic.

PARKE, DAVIS & CO. — 55

Medical Service Members of the Parke, Davis & Company Staff will be in daily attendance at our Commercial Exhibit for consultation and discussion of the various Products listed in our Pharmaceutical, Antibiotic, and Biologic Catalog. Important Specialties, such as Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxytel, Thrombin Topical, Influenza Virus Vaccine, and others will be featured. You are most cordially invited to visit our Exhibit with the assurance that your personal interest will indeed be very much appreciated.

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BILHUBER-KNOLL CORP.

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U. S. VITAMIN CORP. — 56

See and taste for yourself the new and different sodium-free salt substitute—Co-Salt—which actually tastes like salt, looks like salt and sprinkles like salt . . . a great boon to your patients on restricted sodium intake. Exhibit also features new and complete lipotropic therapy—Methischol—the original combination of five proven lipotropic agent: B₁₂, choline, methionine, inositol and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

J. A. MAJORS COMPANY — 57

The W. B. Saunders Company, Medical Publishers of Philadelphia, represented by their Southern Agents, J. A. Majors Company, will exhibit all their latest textbooks and monographs, and each doctor is invited to look them over. Mr. G. E. Finch will be in charge.

CARNATION COMPANY — 62

You are invited to visit our booth where you will see an attractive display on Carnation Evaporated Milk—"the milk every doctor knows." Some valuable information on the use of this milk for infant feeding, child feeding, and general diet will be presented and the method by which Carnation is generously fortified with pure crystalline Vitamin D—400 U.S.P. units per re-constituted quart—will be explained. Interesting literature will also be available for distribution.

BRAYTEN PHARMACEUTICAL CO. — 8

Brayten Pharmaceutical Co. of Chattanooga, Tennessee, is as young in point of service to the Medical Profession as it is modern and realistic in its approach to the problems of today's physician. Since its founding in 1939, Brayten has adhered to its policy of developing and marketing only those specialties which while in keeping with the highest standards of modern research are in answer to definite and recognizable needs. Included among Brayten's specialties are Meta-Cine, the first commercially available acid douche powder; Meta Sert, a vaginal insert which kills *Trichomonas vaginalis* immediately on contact; Theoglycinate, an advance in oral theophylline therapy; and Bromth, a new drug found effective in the prophylactic treatment of premenstrual tension.

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**Doctor: Will you register at each booth  
and show your appreciation of the exhibi-  
tor's fine cooperation and costly outlay?**

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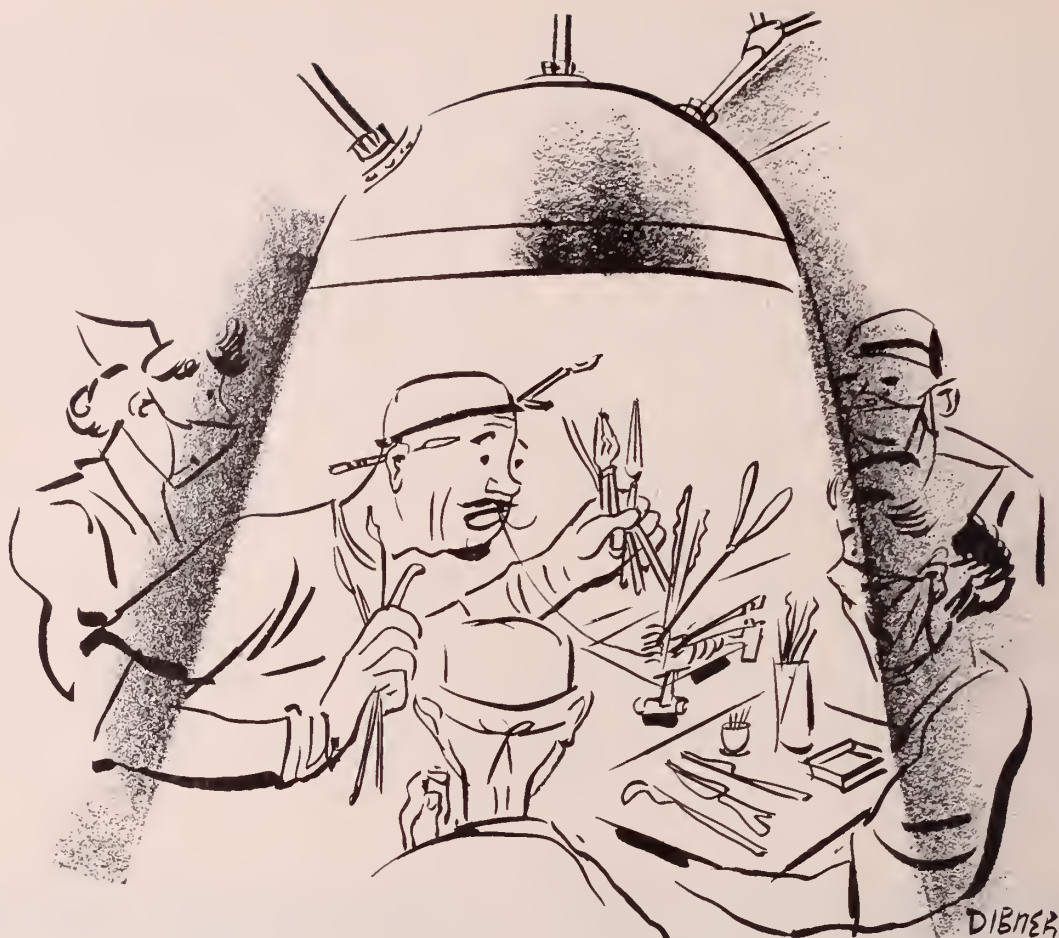
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**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60



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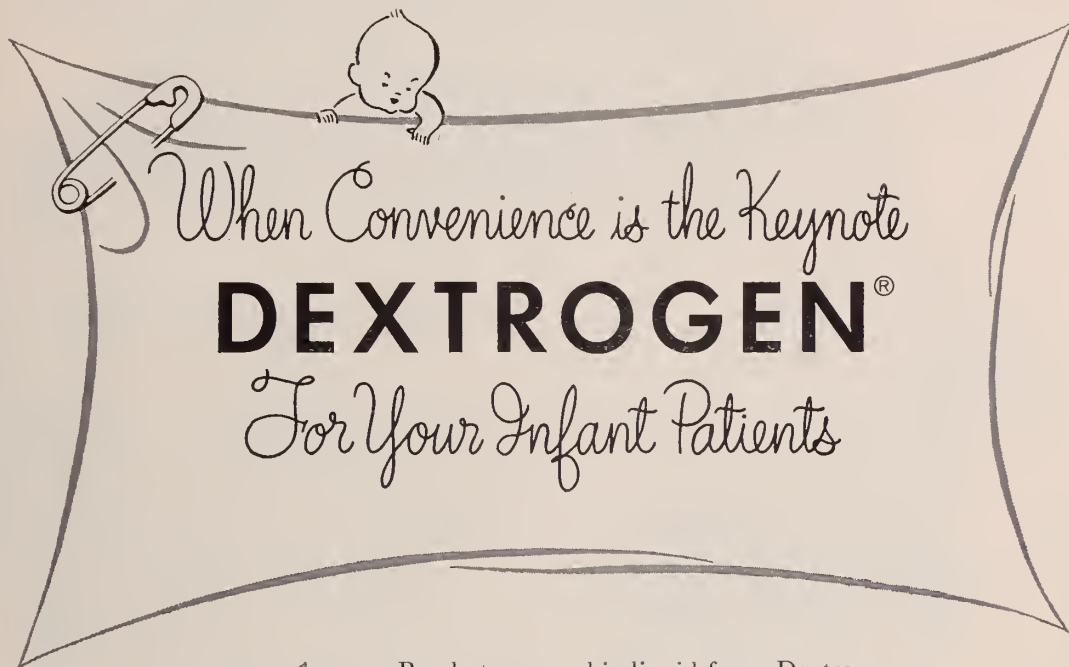
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Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrans, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with $1\frac{1}{2}$ parts of boiled

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The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.



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All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*

THE NESTLÉ COMPANY, INC.
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Have you tried the Aerohalor
in treating
secondary invaders

of the Common Cold?



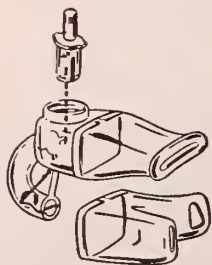
Let us make this point clear at the beginning. We do not recommend penicillin powder inhalation therapy with the AEROHALOR as a cure for the virus cold. It is not. But Krasno and Rhoads¹ have some interesting observations:

"The course of ordinary colds is strikingly shortened by prompt use of the penicillin dust inhalation. We have no illusions that it is effective against virus that initiates the common cold or any other viruses."

The authors also report: "We are fully aware that the etiologic agent of the common cold is probably not a penicillin-sensitive organism. Secondary invaders undoubtedly account for the accentuation of the initial symptoms and in most instances for the more serious complications. Dramatic results often are seen in those patients in whom the cold has been hanging on."

As to the therapeutic effectiveness of inhaled penicillin dust, Krasno and Rhoads state "with assurance" that "bacterial infections of the nasopharynx, para-nasal sinuses, nasal mucosa, larynx and trachea of fairly recent origin, respond well to this form of treatment."

The smoke-it-like-a-pipe therapy afforded by the AEROHALOR is convenient and effective. For the complete story, write for comprehensive literature to Abbott Laboratories, North Chicago, Illinois. **Abbott**



AEROHALOR comes assembled with detachable mouthpiece. Easily interchangeable nosepiece included in package. Disposable AEROHALOR* Cartridge containing 100,000 units of finely powdered penicillin G potassium is prescribed separately—three to an air-tight vial.

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*Trade Mark for Abbott Sifter Cartridge. AEROHALOR and AEROHALOR Cartridge patented in U. S. and Foreign Countries.

1. Krasno, L., and Rhoads, P. (1949), The Inhalation of Penicillin Dust; Its Proper Role in the Management of Respiratory Infections, Amer. Prac., 11:649, July.



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ical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, '51
ical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
est	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Pensacola, 1951
ist	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	Orlando, 1951
est	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Bradenton-Sarasota, 1951
ist	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	Vero Beach, 1951
iality Societies			
General Practice	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	Hollywood, Apr. 22, '51
ty	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	" "
gists, Soc. of	Ralph S. Sappenfield, Miami	Adelbert F. Schirmer, Orlando	" "
a. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
yph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
ers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
iation	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
ec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Society	Nelson A. Murray, Jacksonville	Gretchen V. Squires, Pensacola	" "
sociation, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	" "
Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" Apr. 21-22, '51
ociety	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" Apr. 22, '51
nce Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 2, '51
ks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	Ft. Lauderdale, Apr. 21, '51
ciety, State	D. Morrison, Sr., D.D.S., Gainesville	Larry Schulstad, D.D.S., Bradenton	Hollywood, Apr. 29-May 2, '51
Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando
Service Corporation	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando
Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, June 24-26, '51
Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
sociation, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
utical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
alth Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
sis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Apr. 5-6, '51
Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 22-24, '51
Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Houston, Texas, Dec 4-7, '51
Medical Association	Hamilton W. McKay, Charlotte, N.C.	Mr. C. P. Loran, Birmingham	Dallas, Texas, Nov. 5-8, '51
Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
al Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	St. Petersburg, April 4-6, '51
n Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	Memphis, March 7-10, '51
n, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Hollywood, April 11-14, '51
n Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Gulfport, Miss., October, '51
Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	

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					Total	Paid	
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	Escambia *Santa Rosa	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	7	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	6	1	
	Jackson *Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	11	
	Walton-Okaloosa	Arthur G. William, Jr., M.D. Valparaiso	Calph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	14	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	1	A-2-51 Taylor W. Griffin, M.D. Quincy
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	11	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	50	41	
	Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	4	
	Madison	Julian M. Dukant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	1	
	Taylor *Dixie-Lafayette	Ralph J. Greenc, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	1	217
B	Alachua *Bradford, Gilchrist, Union	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	47	42	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
	Duval *Clay	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	242	141	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	28	14	
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	8	6	
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	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	14	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
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	Lake *Sumter	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	25	17	
	Orange *Osceola	Fred Mathers, M.D. 314 American Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	143	85	
	Seminole	Thomas F. McDaniel, M.D. 315 Magnolia Ave. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	13	12	
	Volusia *Flagler	Peter A. Drohomer, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	63	38	613
C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	160	77	C-5-51 M. Crego Smith, M.D. Clearwater
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	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	181	158	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	41	28	
	DeSoto-Hardee- Highlands- Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Edwin C. Northup, M.D. Box 98 Avon Park	2nd Tuesday 8:00 P.M.	25	22	C-6-52 Leldon W. Martin, M.D. Sebring
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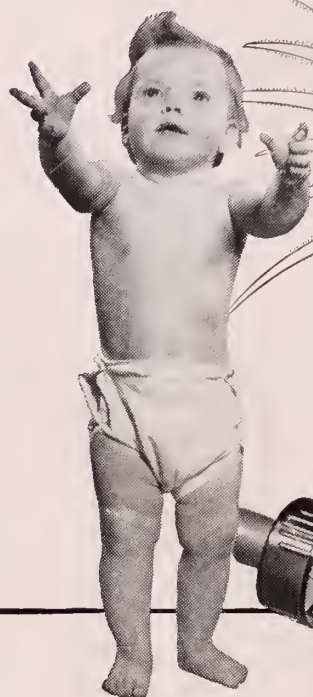
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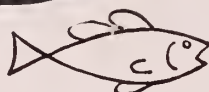
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Vol. XXXVII

APRIL, 1951

No. 10

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IN THIS ISSUE

Dicumarol as an Indicator of Secondary Disease

Milton S. Saslaw
Alexander E. Rosenberg



Infertility in General Practice

John H. Nodine



April Anniversaries

An Editorial



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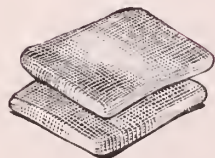
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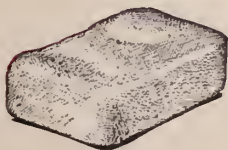


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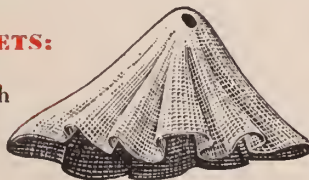
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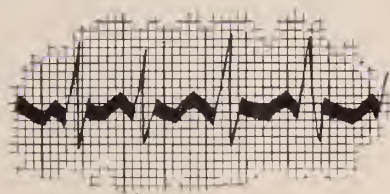
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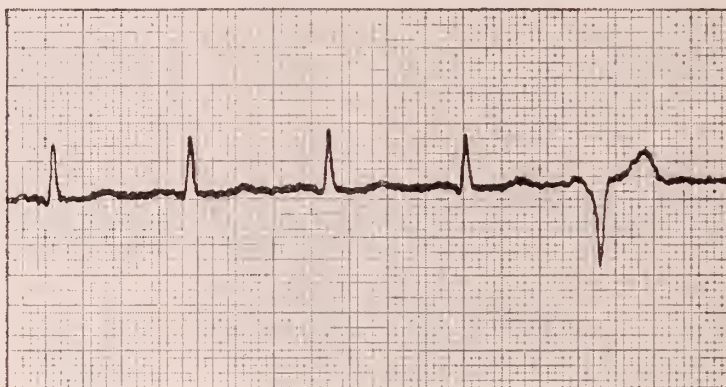
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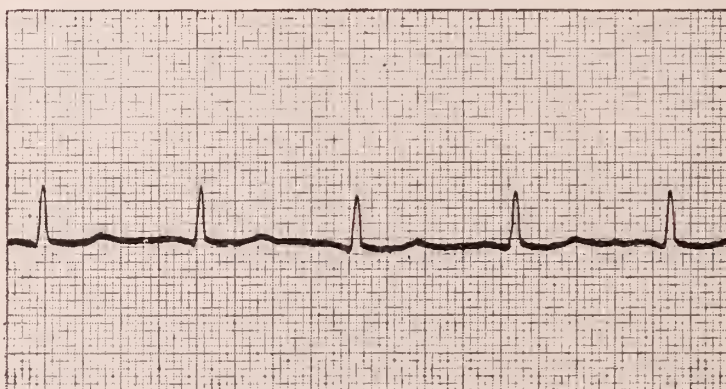
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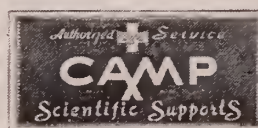
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1. Hutcheson, J. M.: Management of Cardiac Failure. *Virginia Med. Monthly*, 74:458, Oct., 1947.

2. Noth, P. H.: Pick's Disease: A Record of Eight Years' Treatment with Salyrgan, Ammonium Nitrate, and Abdominal Paracentesis. *Proc. Staff Meet. Mayo Clin.*, 12:513, Aug. 18, 1937.

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	Aerobic diphtheroids	3	2	1	0
	S. albus	2	2	0	0
	Aerobic non-hemolytic streptococcus	2	2	0	0
	Ps. aeruginosa	1	0	1	0
With organic or obstructive disease	Ps. aeruginosa	3	1	0	2
	P. vulgaris	1	0	1	0
	A. aerogenes	1	1	0	0
	TOTALS	32	26	4	2

Douglas, R. G.; Ball, T. L., and Davis, I. F.: California Med. 73:463 (Dec.) 1950

*“A good result was recorded when in 72 hours or less the temperature fell to normal, the pyuria cleared, a negative culture was obtained and the patient was symptom-free.”

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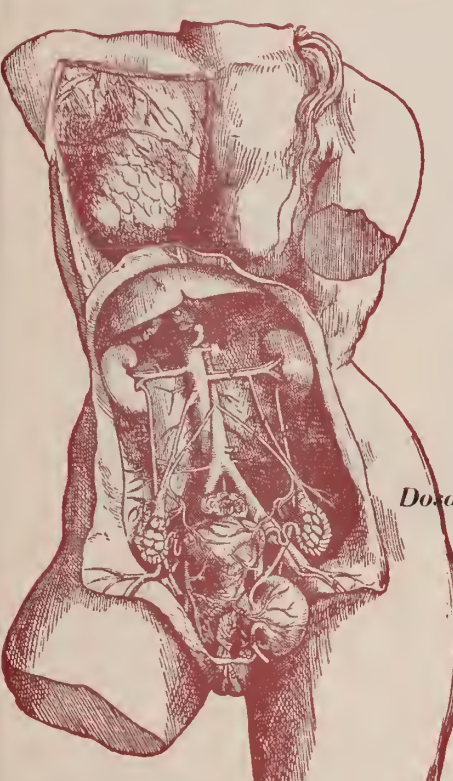
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References:

1. Hammerlund, E. Roy, and Rising, L. Wait, A Comparative Study of the Buffering Capacities of Various Commercially Available Gastric Antacids, J.A.Ph.A., Scientific Edition, 38: 586-588 (1949).
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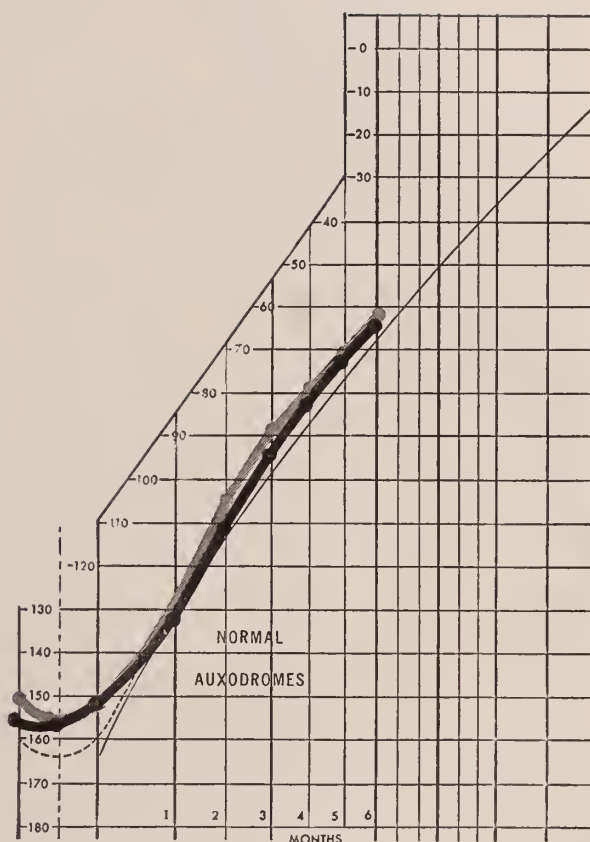
Composite Wetzel Grid auxodrome of 60 unselected infants on S-M-A from birth to 6 months of age.

CURVE B

Growth data, recomputed on Wetzel Grid, based on "selected subjects, most of whom were favored by environment;"² age: from birth to 6 months.

1. Wetzel, N. C.:
J. Pediat. 29:439,
1946.

2. Jackson, R. L.,
and Kelly, H. G.:
J. Pediat. 27:215,
1945.



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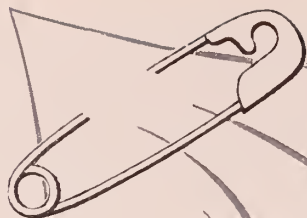
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Dicumarol as an Indicator of Secondary Disease

MILTON S. SASLAW, M.D.

AND

ALEXANDER E. ROSENBERG, M.D.

MIAMI BEACH

In addition to its established position as a therapeutic agent in vascular disorders, dicumarol may sound a warning signal of serious illness. This serious disease may be related in no way to the condition for which the dicumarol is being administered. In the following series of 4 cases dicumarol was administered for coronary thrombosis in 2 cases, suspected coronary thrombosis in 1 case, and arterial embolism in 1 case. In each of these cases bleeding occurred and was presumably due to diminished prothrombin activity, but on careful investigation proved to originate from some other occult source.

Report of Cases

Case 1. — A 48 year old white woman had been treated for fifteen months because of anginal pain in the chest and hypertension. The blood pressure had reached a maximum of 200 systolic and 120 diastolic. On Dec. 23, 1947, she suffered excruciating pain in the chest and back, and was hospitalized for suspected coronary thrombosis complicating hypertensive heart disease. Because the patient had reacted poorly to previous medication, all drugs were given cautiously. Dicumarol was given, never in excess of 200 mg. in one day. The total dosage was 750 mg. over a nine day period. The prothrombin time did not exceed thirty-seven seconds until the day after the cessation of therapy, when it reached forty-seven seconds. On this day, petechial spots appeared, and the drug was discontinued.

Several blood counts had been taken over the course of the patient's illness, and only a mild secondary anemia was indicated. On hospitalization, the white blood cell count was reported by telephone as being 5,500. No differential count had been made at that time. When the petechial spots appeared, a repeat blood count revealed the presence of acute leukemia. The disease was considered to be a monocytic phase of acute myelogenous leukemia. Its further course was typical of an acute leukemia, and the character of the cells changed from the monocytic type to the myeloid form. The patient expired on Feb. 12, 1948. Postmortem examination confirmed the diagnosis.

Case 2. — A 52 year old white man was admitted to the hospital on Jan. 29, 1949, because of acute myocardial infarction. The electrocardiogram showed the pattern of an acute anterior infarction. Dicumarol was administered

so as to maintain the prothrombin time under thirty seconds. On February 10, there developed rectal bleeding at stool. The prothrombin time was twenty-three seconds. Rectal examination revealed numerous pin-point bleeding areas over the posterior hemorrhoidal surfaces. Because of the deep red color of the blood, the proctologist was not satisfied that the bleeding was of hemorrhoidal origin, but because of the patient's cardiac status, sigmoidoscopic examination was postponed.

The prothrombin time reached a peak of thirty-eight seconds, but with reduction in dosage, it fell to twenty-two seconds. On February 17, blood-streaked stools were again observed. On March 6, the patient was discharged from the hospital and remained symptom-free for five months. On August 12, on sigmoidoscopic examination, an ulcerated mass was found 18 cm. above the anal verge, which on biopsy proved to be an adenocarcinoma. Resection was performed at another hospital. For one year the patient has been asymptomatic.

Case 3. — A 42 year old white man on Feb. 19, 1950 had an acute attack of excruciating pain in the right leg. He was found to have rheumatic heart disease, auricular fibrillation, hypertension (180/140), and arterial embolism with impairment of circulation to both lower extremities. Dicumarol was administered, and the prothrombin time was maintained below thirty-six seconds. On the fifteenth day of treatment, it rose suddenly to sixty-eight seconds, but returned to thirty-nine seconds in two days. One day later, rectal bleeding developed. The patient was hospitalized, and under saddle block anesthesia, sigmoidoscopic examination revealed a necrotic, ulcerated, fixed mass on the anterior wall of the rectosigmoid, 16 cm. from the anal verge. Biopsy studies verified the clinical diagnosis of adenocarcinoma.

On March 29, at another hospital, the pelvic colon was resected, and an end to end anastomosis and colostomy were performed. The liver, gallbladder and other viscera were all apparently normal. The colostomy was later repaired, and the patient has been asymptomatic since.

Case 4. — Following two weeks of intermittent anginal pain, a 72 year old white man suffered an acute myocardial infarction on Jan. 14, 1950. Because of the patient's age, caution was exercised in the use of dicumarol. Two hundred milligrams was administered the first day and 125 mg. the second. Thereafter the daily dosage ranged between 75 and 125 mg., with the prothrombin time being maintained between thirty and thirty-four seconds. On January 27, the prothrombin time suddenly rose to forty seconds, and on the following day, the patient passed grossly bloody urine. Large doses of synkavite failed to stop the bleeding, which finally ceased a week later after a transfusion of 250 cc. of whole blood.

Dicumarol was not administered after January 28. The following prothrombin levels (Quick's method), however, were recorded:

	Prothrombin Level	Control
Jan. 30	52 sec.	13 sec.
Jan. 31	58 sec.	15 sec.
Feb. 1	52 sec.	13 sec.
Feb. 2	50 sec.	14 sec.
Feb. 3	38 sec.	12 sec.
Feb. 4	40 sec.	16 sec.
Feb. 5	55 sec.	14 sec.
Feb. 6	38 sec.	13 sec.
Feb. 7	36 sec.	14 sec.
Feb. 8	17 sec.	13 sec.
Feb. 9	18 sec.	15 sec.
Feb. 10	19 sec.	14 sec.

The patient refused a urologic survey locally and went North for follow-up studies. These were reported as revealing a papilloma of the bladder, visible on contrast studies and cystoscopically.

Comment

In each of the cases recorded, dicumarol was administered because of a specific indication, or because a specific indication was thought to exist. In each case, bleeding occurred, and search for the cause of the bleeding revealed that there was an underlying cause. The bleeding was not merely due to the use of the drug.

Butler and James¹ recorded a case of major bleeding following a single dose of dicumarol of 300 mg. The patient expired, and the cause of death was found to be another underlying condition, periarteritis nodosa.

The usually recorded contraindications to the use of dicumarol were considered in each case. These contraindications or conditions in which increased risk is known to exist, include poor laboratory control,² renal or hepatic dysfunction, blood dyscrasias, subacute bacterial endocarditis, recent operations on the brain or spinal cord, open ulcers, granulating wounds, drainage tubes, nutritional deficiency,³ dissecting aneurysm of the aorta, hypertension with old history of cerebrovascular accident,⁴ heart failure, pregnancy and the first five postpartum days, enterocolitis,⁵ and active tuberculosis.⁶ Naturally, in all the cases present-

ed, there was a contraindication, but this contraindication remained undetected until after the use of dicumarol.

No doubt, extensive use of the anticoagulants will continue to uncover more and more conditions that would otherwise pass unsuspected. In this regard, dicumarol may serve as the signal of a serious condition unrelated to the primary disease, and careful search may reap the reward of early diagnosis and possible cure of an illness that might otherwise be discovered too late for help.

Summary

Four cases are reported in which dicumarol was given because of vascular disease or suspected vascular disease. In each case, bleeding occurred while the prothrombin time was within therapeutic range or close to it. In each case, search for the cause of bleeding revealed another underlying cause for the abnormal hemorrhagic response.

The careful physician will not accept the administration of dicumarol in therapeutic or near therapeutic range as *prima facie* evidence that the drug has caused bleeding, but will investigate to determine whether there is any other pathologic condition to explain it. The reward for such a search is the possibility of instituting specific therapy early enough to be of benefit in otherwise probably incurable conditions.

We are indebted to Dr. Victor H. Kugel for information concerning and permission to present case 2, and to Dr. Paul N. Unger for case 4.

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Infertility in General Practice

JOHN H. NODINE, M.D.

BRADENTON

Most cases of infertility first come to the attention of a general practitioner. These cases may be disguised under other complaints, and often are picked up as an incidental finding neglected by the patient due to guilt complexes, superstition or ignorance. Even when desiring treatment for infertility, patients may come in asking for a general check-up, hoping to avoid the embarrassment of bringing up the chief complaint. One must be alert to these devious approaches, since the usual check-up would be of little value in an infertility problem. A routine question as to the number of children and, when there are none, an inquiry into the desire for children often tactfully bring the subject to the point. Remember that 10 to 15 per cent of all marriages are childless and that at least in one-third to one-half of these there can be satisfactory treatment.

The scientific investigation of infertility revolves around three major questions: (1) Is the specimen of seminal fluid adequate and is it delivered to the cervix? (2) Is the woman ovulating? (3) Are the fallopian tubes patent? The investigation should begin with the first two questions, and only later should the tubes be evaluated.

Seminal Fluid

Most criteria for judging an adequate seminal specimen are based upon studies of infertile marriages in which ultimately there are children. Obviously these criteria are open to question; so, at present, MacLeod of Cornell is studying routinely the seminal specimens of the husbands in a large series of obstetric cases, to arrive at more nearly standard criteria. Examinations of seminal fluid may be made with no more equipment than is usually present in the general practitioner's office. The volume may be measured in a graduated pipet or in a cylinder. Viscosity may be estimated by observing the flow from a pipet.

Normally the flow consists of sticky droplets. Motility may be estimated by observation of a drop of undiluted seminal fluid; a count is performed by dilution with tap water in a pipet used for counting white blood cells, and counting in the chamber as for a red blood cell count. The number

of cells counted in this area gives the count in millions per milliliter. Normal values are generally believed to be in excess of 60 to 100 million per milliliter. The actual count per milliliter is probably more important than the total number of spermatozoa in the ejaculum, since only a small volume of the seminal fluid can come in contact with the cervix. The per cent of abnormal forms present can be determined from a dried slide stained with crystal violet (1 per cent in distilled water). No statement of infertility should be based upon a single examination, since there is great variation in the sperm count of the same person.

At least a cursory examination of the husband is indicated to rule out local abnormalities such as hypospadias, cryptorchidism and testicular atrophy. When the sperm count is normal, but the volume is low, or hypospadias is present, artificial insemination with the husband's seminal fluid is indicated. When the sperm count is low, a complete examination and history of the husband should be undertaken to rule out hyperthyroidism, hypothyroidism, cardiac disease, renal disease, anemia, recent febrile disease, tuberculosis, the use of spermatotoxic drugs like atabrine, industrial exposure to benzene derivatives, excessive use of alcohol or tobacco, exposure to roentgen rays, recent or old gonorrhea with prostatitis or orchitis, postpuberty mumps with orchitis, diabetes, testicular tumor, past or present hernia, poor diet, overwork or insufficient rest.

If correction of these factors fails to cause the sperm count to return to normal, thyroid extract may be given empirically, and eventually a testicular biopsy is indicated. This can be done under local anesthesia in an ambulatory patient. When the sperm count is extremely low, or when no spermatozoa are present, testicular biopsy is advisable at once. If this biopsy shows active spermatogenesis, obstruction of the vas deferens is suspected, and the patient should be referred to a urologist for diagnosis and treatment. It has been thought that cryptorchidism itself is a cause of infertility, but more often, aplastic infertile testes are the cause of cryptorchidism since they cannot respond to the usual stimuli to descend,

An abdominal testis which is normal is often fertile, although it may be more fertile after it is delivered surgically into the scrotum. There can be little increase in fertility expected from surgically moving an aplastic testicle into the scrotum. There have been no well controlled studies showing increase of spermatogenesis from gonadotrophic hormones or testosterone.

Ovulation

In the wife the presence of a normal menstrual cycle does not necessarily mean that ovulation is taking place. Anovulatory menstrual cycles occur two or three times a year in most women. A basal temperature curve is the best means of ascertaining the presence, as well as the time, of ovulation. Temperature should be taken in bed before arising and should be recorded daily. The usual pre-ovulatory temperature runs between 97 and 98 F., while after ovulation it runs between 98 and 99 F. There is often a jump of $\frac{3}{5}$ of a degree on one day about fourteen days before the onset of the next period. There should be no intercourse for about 5 days before this jump, and intercourse should be advised twice on the day of the jump. The basal temperature curve is particularly valuable when the patient's periods are irregular.

When the basal temperature curve is not conclusive or is impossible to obtain, an endometrial biopsy should be done about one week before the expected period. This may be done in the office after a codeine hypodermic. The curvature of the biopsy cannula is opposed to the uterine curvature, and by applying suction to the cannula and pressure against the concave wall of the uterus, a single stroke should remove a thin strip of endometrium which is adequate for histologic study, with minimal discomfort to the patient. The presence of a secretory endometrium shows that ovulation has taken place. Mouse and rat hyperemia tests and urinary pregnanediol excretions, when available, are of value in detecting and timing ovulation.

The value of hormonal therapy in the anovulatory woman has been highly disputed, but it is now little used. The pituitary gland secretes three gonadotrophic hormones: (1) the follicle-stimulating hormone (FSH), which permits the development of the ovarian follicle; (2) the luteinizing hormone (LH), which brings about ovulation and formation of the corpus luteum; and (3) the luteotrophic hormone (LTH), which maintains the corpus luteum throughout the cycle or throughout pregnancy when present. The follicle-stimu-

lating hormone has been shown to be of no value in bringing about ovulation. There is no adequately pure preparation of the luteinizing hormone available, and the luteotrophic hormone has been shown to have no effect on the ovary until after ovulation has taken place. The production of the luteinizing hormone by the pituitary gland, however, is known to be stimulated by estrogen; so small doses of estrogen given during the first two or three weeks of the cycle may be of value. Larger doses will inhibit the formation of the follicle-stimulating hormone and thus prevent maturation of the follicle.

Local and general diseases must be ruled out, as in the case of the husband. Cystic ovaries, fibroid tumors, endometriosis, pelvic inflammatory disease, cervical erosions, carcinoma of the fundus and congenital abnormalities of the vagina and uterus must be diagnosed. Except in cases which are hopeless from the fertility point of view or in cases in which carcinoma is found to be present, all surgery for these abnormalities should be conservative. Some of the most excellent results obtained in the field of infertility have occurred after splitting the capsule of polycystic ovaries. Eighty to 90 per cent of the women in these cases then have children. Results from conservative surgery of endometriosis and fibroid tumors are not so spectacular, but indicate the procedure unless the case is far advanced. Systemic diseases, such as diabetes, thyroid disease, renal disease, cardiac disease, exogenous toxins and poor diet, should be adjusted to as nearly normal as possible. The absence of ovulation may sometimes be overcome by the use of thyroid extract in large doses (3 or more grains per day) even in the absence of hypothyroidism. As a final resort, and not without some risk, low dosage roentgen therapy of the pituitary and ovaries may bring about a transitory ovulation for several months following the stimulating dose.

Patency of the Fallopian Tubes

The basal temperature curve may reveal the typical spikes of pelvic inflammatory disease, and thus it is desirable to have a record of at least one month's duration before performing a Rubin test. If the history, temperature chart or pelvic examination suggests past or present pelvic inflammatory disease, determination of the sedimentation rate is indicated, since there is considerable danger of peritonitis following a Rubin test when pelvic inflammatory disease is present. Another complication of this test which has been

noted is aeroembolism, but this can be prevented by the use of carbon dioxide instead of air. A small cartridge with a valve, a sphygmomanometer and uterine cannula are the basic equipment for this test. Pressure should never exceed 200 mm. of mercury, or the uterus may be ruptured. There are complicated apparatus available, which prevent excessive pressure, permit constant flow of the gas and record intrauterine pressure and tubal contractions, but usually the specialist is the only one who performs a sufficient number of tests to make this type of apparatus practical.

If the tubes are closed during a single examination, it is still possible that the closure may be due only to tubal spasm, and repeated examination is indicated, with trasantine given before it. I know of one persistent patient who had eleven Rubin tests with negative results over a period of six years, but the reaction to the twelfth test was positive, and she became pregnant the same month. Incidentally, the Rubin test is the only medical test in which a positive result is normal. After several Rubin tests with negative results, the exact site of the obstruction may be determined by hysterosalpingography, after injection of lipiodol. Surgical procedures in opening tubes have proved generally unsatisfactory, and their recommendation depends upon the extent of the patient's desire for children as well as upon the site of the obstruction. Seldom have such operations shown over 5 to 10 per cent success in overcoming infertility.

Other Considerations

When all three primary factors are normal, and the patient still fails to become pregnant, desiccated thyroid may favor implantation. Her cervical mucus may be mixed with seminal fluid at the time of ovulation, and hostility of this mucus may sometimes be overcome by alkaline douches or by artificial insemination with the husband as donor. Normally, the spermatozoa should penetrate the cervical mucus like a chain of ants on the floor.

Psychologic factors may also be of importance in infertile women who ovulate and have open tubes. Psychoanalysis of a series of them has shown that they generally have an extreme subconscious resentment of their mothers, and failure to conceive is a mechanism by which they prevent a similar hostility from being directed against themselves. The exact mechanism is presumed to be increased uterine contractions which expel the seminal fluid from the uterus and which prevent

implantation later if fertilization has taken place. A number of these women have become pregnant during psychoanalysis, but the pregnancy often results in spontaneous abortion.

With a completely sterile male and a fertile or subfertile female, artificial insemination with an outside donor may be attempted. The legal status of this procedure has not yet been ascertained by any case in court or by legislation in this country. It is thus advisable to have written permission given by both husband and wife as well as the donor and to have the baby legally adopted by the husband after its birth. The donor should remain unknown to the husband and wife, and similarly they should remain unknown to him. If the husband has any sperm cells in his seminal fluid, it is desirable to mix his specimen with that of the donor so as always to leave the possibility open that the child is his.

The technic for artificial insemination is varied, but it is generally believed that the sperm cells should be introduced only into the cervical canal, since violent uterine cramps ensue when seminal fluid is instilled into the uterus, and that the posterior blade of the speculum should be kept in place for fifteen to twenty minutes so that the cervix may be bathed in a pool of seminal fluid. With fertile women, a single insemination on the day of ovulation results in pregnancy in about 80 to 85 per cent of cases.

Conclusion

The problem of infertility is not a simple one, and the patient should be so advised. Generally the psychologic makeup of the patients is such that they do not become discouraged easily and continue to follow through with the studies as though they were under compulsion. There are no new miracle hormones or enzymes available for the treatment of infertility, for the efficacy of a treatment for a single type of infertility must be evaluated by well studied cases and well controlled series before it can be proved. At the meeting of the American Society for the Study of Fertility and Sterility last June, the chairman cautioned against the overenthusiasm with which the members had grasped at the "hyaluronidase bubble," only to find it exploding in their faces after an adequate test. The problem demands a long careful study of both husband and wife accompanied by such measures as can be carried out by the general practitioner with judicious consultation of various specialists in certain selected cases.

Rhinoplasty

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Rhinoplasty is a type of surgery in which the surgeon deals primarily with esthetic defects of the nose. The nose consists of the following bony structures: the frontal processes of the superior maxilla, the nasal bones and the radix nasi, which constitute the glabella. The cartilaginous portion comprises that part of the septum which lies in front of the anterior nasal spine, the lateral cartilages, which usually blend into the septum, and the alar cartilages with their columellar extension, which forms the tip of the nose. The anterior nasal spine may also be included, since it is often involved in nasal malformations.

This bony and cartilaginous framework weighs about $1\frac{1}{2}$ ounces. That the arrangement of these small bony structures which make up approximately $1/500$ of the bony framework of the body should play such an important part in the world's history is most remarkable. Nature's pranks, accidents, disease and heredity have arranged these small structures in many diverse ways, and since the beginning of time, character, success and failure, happiness and misery, in all phases, have often been dependent on the arrangement of these small structures. The fate of many women and men depends on the tilt or hook of the nose.

Hooked noses, though they are of common occurrence, are regarded as special racial characteristics, although this view is hardly justified by anthropologic data. When patients with large crooked noses ask to have them reduced to normal, they do so for various reasons. In the majority of cases, they are motivated by the desire to be like other average normal people; they want no more and no less. In other instances, the reason is that they are often the victims of cruel humor, such as mockery and derisive laughter, and in some there is the wish to escape racial hatred, a curse of our civilization.

Persons come to the rhinoplastic surgeon with a set purpose. They always know what they are after and why. The crooked, hooked nose is often the cause of psychic and even physical restrictions. Actually, the reason almost always arises from a conscious social purpose. The patient will always be able to tell his or her reason for requesting an operation.

The artistic anatomy of the face is based on certain accepted proportions and relationships of the component parts which are considered normal, and from which any radical deviation is considered abnormal or unesthetic.



Before Operation



After Operation

In civilian practice the majority of nasal defects encountered are hereditary. Essentially there are two types: the purely traumatic deformity which disfigures an esthetically normal nose; and the one in which trauma adds an additional element to a hereditary esthetic defect of the nose. When the traumatic deformity of the external nose is accompanied by an injury to the septum, to the extent that secondary changes occur in the inner chambers of the nose, the external deformity becomes of secondary importance and its correction should be postponed until such time as everything possible in the way of a cure for the intranasal condition has been effected.

When a person with a prominent nose is to have the prominence reduced to normal, the bony elevation is cut down to the desired level, and then the cartilaginous elevation is modified by slicing down the dorsum of the septal cartilage which determines the profile and the elevation of the nasal pyramid. The length of the nose depends on the length of the septal cartilage. The shortening of the nose is accomplished by cutting off a wedge at the lower end of the septum and suturing the columella to the remaining portion of the septal cartilage.

The narrowing of the bridge is a carefully planned medial fracture of the lateral walls, which behaves in the same manner as an unpremeditated fracture. If the fracture is incomplete (greenstick), it will tend to right itself, and a broadened nasal bridge often results. If the web of the radix nasi interferes with a complete fracture of the lateral walls, it can be overcome by crushing the web with scissors or a chisel.

While every step in rhinoplasty is important, the nasal tip is unquestionably the most important, and incidentally the most difficult. The chief function of the lower alar cartilages is to support the nasal tip. The resecting, wedging and dovetailing of these cartilages, plus the conservation of mucous membrane in the proper places, determine the appearance of the nasal tip.

Shaping the tip of the nose is a procedure carefully planned so that the tip, together with the rest of the nose, will form a harmonious outline with the other features of the face. The elevation of the septum, the size and contour of the alae, the configuration of the alae and the width of the base are all problems in shaping the tip of the nose. At the same time one must remember that modern taste requires a definite angulation at the base of the nose.

When the nares are abnormally large, whether the cause is an elevated septum, enlarged alae or a widened nasolabial junction, they can be reduced in size by proper resection and suturing at the bases of the alae.

Postoperative swelling depends on the degree of trauma; the greater the trauma the greater the swelling and reaction will be. Postoperative dressings, particularly sufficient pressure to maintain the operative position of both nasal bones and tip, are of the utmost importance in achieving a good result.

Harmony of the facial contour requires a definite proportion between the forehead, nose, lips and chin. Disregard for this is responsible for many esthetic failures even when rhinoplasty is



Before Operation



After Operation

*Before Operation**After Operation*

properly performed. A poorly proportioned lip or chin will prevent the establishment of an acceptable profile and calls for simultaneous correction. If at all possible, any gross flaw in the chin should be corrected simultaneously with rhinoplasty.

Rhinoplasty is surgical craftsmanship. It, therefore, can be good, bad, or indifferent. Good results depend on a thorough understanding of the anatomy, functions and relationships of the parts plus manual dexterity in modifying the form of these structures.

The external nose is not a complicated organ, but every external nose presents a complete problem of its own. Rhinoplasty has its limitations. Training and experience are major factors in se-

lecting cases for operation. In remodeling a misshapen nose into one that has a pleasing appearance, one must possess a good understanding of nasal anatomy and physiology and a proper respect for both, and a fine sense of the esthetic.

Good results depend on good judgment, manual dexterity, and a proper appreciation of what constitutes good esthetic form, plus the ability to produce the best possible results from the material at hand.

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*Before Operation**After Operation*

Veterinary Public Health

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Veterinary Public Health is the link between public health and agriculture. Animal health has long been a concern in the economics of agriculture; in recent years, however, disease hazards on the farm have brought animal health to the attention of public health workers. Some animal diseases have little or no economic significance, inasmuch as they do not interfere with the production of animal products, but they are of definite importance to public health.

Animal diseases extend into urban areas through food products of animal origin and as occupational disease hazards. The control of these food-borne diseases is effected by adequate meat and milk inspection. The occupational diseases can only be controlled by controlling or eradicating the animal diseases on the farm.

Rabies and brucellosis are two animal diseases that affect most all parts of the United States, as well as Florida. With what is known, however, and with the vaccines available today, there is no logical reason why rabies should continue to exist. Recently, a new vaccine has been given a special license by the Bureau of Animal Industry — Rabies Vaccine, modified virus (chick embryo origin — vacuum dried) avianized by several passages through embryonated eggs. Many believe that a single injection of this vaccine will, in all probability, confer a lifetime immunity in the dog. Trials have not been in progress long enough as yet to prove that it will, but general experience with live virus vaccines, such as those of yellow fever and smallpox in humans, is indicative. Rinderpest and Newcastle diseases in animals produce a longer lasting and more solid immunity than killed virus vaccines. In the near future, united efforts should be made to eradicate completely, once and for all, this animal disease that has been a menace to man down through the ages.

Only 86 cases of human brucellosis were reported in Florida in 1949. This number appears much too low as compared to the disease incidence in the animal reservoir. In the past year, out of nearly 100,000 (99,456) cattle tested for Bang's

disease or brucellosis, 10,579 were infected. Brucellosis is an economic problem as well as a public health one. It is said it reduces a dairy cow's efficiency 20 to 25 per cent, and in addition there is the loss in veal and meat which results from the harboring of infected cattle. Brucellosis in the human is not a problem which can be completely controlled by pasteurization of all dairy products, as it is also an animal disease communicable to man by direct contact. Other animals besides the dairy cow are factors, and possibly of just as serious a nature to our rural population as those persons exposed by their occupations, which bring them in close contact with the animals or animal food products. Human brucellosis, therefore, must be controlled by the eradication of the disease in the animal reservoir.

Cows

The cow has been called the foster mother of man, but through her meat and milk, as well as close association, she is also a prolific source of disease. Dr. C. S. Bryan, Dean of Michigan State College, School of Veterinary Medicine, stated that 86 per cent of the dairy herds and 26 per cent of the cows are infected with mastitis. It has been estimated that 1 cent of the price of a quart of milk represents loss due to mastitis. Dr. Bryan tells the story which might be true in rural Florida, or, for that matter, in some of our urban areas. A family milked its animal in the evenings and, not knowing how to care for the milk, allowed it to stand at room temperature, providing a good incubation period. The animal was fed for the night and appeared healthy. Later that night, the father and the two children consumed about a half pint of this milk. In a matter of hours they were sick from food poisoning, from which the two children died. The milk animal, of course, had a staphylococcal mastitis. The staphylococci reproduced in the milk at room temperature, producing the enterotoxin which caused the illness. Pasteurization would not have destroyed this enterotoxin.

Anthrax, which has been diagnosed in Florida, might be infectious to man either by direct contact with the live or dead animal or by contact with the hides, wool or meat products. The neighboring states of Alabama, Mississippi and Louisiana, as well as Cuba, have this disease rather widespread in areas. Constant vigilance, therefore, must be exercised. Other diseases of the cow include the beef tapeworm and cowpox, which in the United States is rare except when the virus is transmitted back to the cow by persons recently vaccinated for smallpox. Q fever, a rickettsial disease of which the cow is the ideal host as no outstanding clinical symptoms are evidenced by her, has caused considerable concern in the Western United States. The ticks involved in Q fever in the United States are the Lone Star tick (*Amblyomma americanum*) and the wood tick (*Dermacentor andersoni*), both of which are native to Florida.

Milk sickness, arising from a chemical poison found in milk of cattle which have eaten white snakeroot, was a somewhat common disease of man in the pioneer days; also it occurs on rare occasions today in those persons who are not familiar with the plant and allow the family cow to graze in wooded areas. These are but a few of more than a score of diseases of the cow transmissible to man.

Horses

The horse, with its important part in the development of civilization, is a rather unimportant source of human infection. Glanders is the only disease which is distinctly of equine nature, the horse being the only reservoir, and few human infections have been diagnosed as such. It has now been eradicated in the United States and Canada. Equine encephalomyelitis is a serious infection both in man and horses in epidemic season. Anthrax and brucellosis also occur in the horse. Horses, however, are relatively an unimportant source of human infection compared with the other animals.

Swine

Swine are responsible for a considerable number of human infections. Five bacterial diseases of importance are transmitted to man. Anthrax is acquired by handling the animal and its hide and bristles. Brucellosis is acquired by contact; the persons most in danger are butchers, abattoir workers and farmers. *Brucella suis* and *Brucella*

melitensis infect hogs, and recently *Brucella abortus* has been isolated from them. Many types of *Salmonella* have been recovered from swine. Swine erysipelas is of economic importance, and human infections are often acquired by contact with the hogs. Both human and bovine tuberculosis may be contracted from uncooked garbage being fed to swine and association with infected cattle. The animal parasites, because of the nature of the hogs, are numerous. Among the twenty-four helminths which infect hogs, nine are transmitted to man. Trichinosis is the most serious. This, together with the pork tapeworm, may have been responsible, in part at least, for the ancient Jewish prohibition of pork.

Sheep and Goats

Sheep and goats in their relationship to public health are of minor significance. Sheep rank next to goats in susceptibility to brucellosis. *Salmonella* food poisoning occasionally comes from eating infected animals. Rocky Mountain spotted fever and tularemia both occur in sheep, and in humans who have been bitten by wood ticks from infected sheep, or have crushed the ticks from the wool in their fingers.

Dogs

Dogs enjoy a much more intimate contact with man than any other animal. They share not only his dwelling but sometimes his bed, thereby exposing him to several diseases from which they suffer. We have already discussed rabies and the fact that it can be controlled, as several countries have proved. Leptospirosis, or Weil's disease, is becoming an increasing problem in dogs, with human infections by both *Leptospira icterohaemorrhagiae* and *canicola*. Tularemia is sometimes present in dogs, as is Rocky Mountain spotted fever. Much work has recently been done and is still being done by the State Board of Health in regard to *Salmonella* infection in dogs and the possibility that it is a source of human infection.

A large number of parasites are found in dogs, but only a few are of public health significance. The dog tapeworm is acquired by man from swallowing an infected flea, or parts of it, following crushing it with the fingers. Creeping eruption or larva migrans, possibly of most public health significance, is due to *Ancylostoma braziliense*, or one of the dog hookworms. Dr. Roger F. Sondag, former Director of the Bureau of Preventable Diseases, conducted a survey in 1949 in which 1,100 physicians were contacted to determine the inci-

dence of larva migrans or creeping eruption. This survey was the result of many complaints of tourists in the various resort areas. Five hundred and fourteen physicians reported 7,781 cases in the previous six months. A study of the incidence of infection in the dog and cat with *A. braziliense* was started and is still being conducted. Approximately 58 per cent of all animals posted were hosts to *A. braziliense*. Various chemicals are being tried with reference to their larvicidal action in the treatment of the soil. Several promising ones for beaches, school yards, sand boxes, and the like are available, but as they kill grass as well as the hookworm larvae, additional work with other chemicals will be done.

Birds

The chicken and other birds have a growing importance as a carrier of human disease. The virus of equine encephalomyelitis and that of St. Louis encephalitis find a natural reservoir in the hen. Many types of *Salmonella* bacteria are found in poultry. The psittacine birds are of consequence because of psittacosis. Newcastle disease of chickens, rather a newcomer to the United States from Australia, has become widespread throughout the United States with consequent human infections in poultry men and laboratory workers.

Wild Animals

Even the wild animals are a source of human infection. The monkey in its wild state carries the virus of jungle yellow fever. It is infected with several parasites causing diseases communicable to man, such as amebiasis, balantidiasis and schistosomiasis. Bacterial infections with such organisms as *Shigella* and *Salmonella* are common. The coyote, fox, coon and skunk suffer from rabies and make it difficult to eradicate the disease in dogs. Rabbits are the chief cause of tularemia in man, although the etiologic agent may be present in other animals and rodents.

Veterinary Public Health Service

It is the Public Health veterinarian's function to cooperate with and coordinate the efforts of the various agencies concerned, the state, county and city Health Departments, the Florida Live Stock Sanitary Board, the U. S. Bureau of Animal Industry in its local office, local physicians and practicing veterinarians in the control and elimination of these diseases communicable to man from animals and animal food products.

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Glyseennid

Results of Its Use in Fifty-One Cases

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KEY WEST

Cathartics and laxatives are among the most ancient medicaments, and before the modern medical era, they were the principal and sometimes the only internal medication for a great variety of illnesses. Cathartics may be classified into five groups: (1) parasympathetic stimulants; (2) muscular stimulants; (3) capillary poisons; (4) those whose action depends on mechanical distention, and (5) lubricants.

One of the oldest cathartics known is senna, common as a household remedy in the form of "senna tea." In the last few decades, however, the medical profession has not looked with favor on senna as a laxative because of the variability in

potency of the preparations available, and because of extremely unpleasant side effects of nausea, vomiting and cramping.

The action of senna as a laxative depends upon its stimulation of muscular activity; hence it falls into the second group in the classification mentioned. Stoll, Kussmaul and Becker¹ were successful in isolating several active principles of senna, among them two specific glycosides, which they called sennosides A and B. These substances are isomeric and have the same empiric formula, $C_{21}H_{20}O_{10}$. They appear as light yellow crystals and display characteristic physicochemical constants. Hydrolysis cleaves the two glycosides into

aglycones in the molecular proportion of 1:1. Oxidation of the aglycones leads to the anthraquinones known as rhein.

Straub and von Bergmann² showed that the combined sennosides and particularly the A fraction, produce the desirable laxative effect of senna, and that emodin, which occurs free in the leaves, is responsible for the undesirable effect of cramping and griping. The laxative effect of senna results from peristaltic stimulation of the colon. Straub and Triendl² studied the effect of the glycosides of senna on the cat. Oral administration required six hours for effective action, and parenteral administration required five hours. Intravenous administration produced results in one hour. In clinical patients, ten to twelve hours are required for action of the sennosides.

Clinical Study

As a practicing surgeon, I have found it interesting to observe the radical change that has occurred during my professional life in the attitude toward purgation of patients before an operation. Thirty years ago, and for some time afterward, it was accepted as a general rule that the intestinal tract should be thoroughly cleansed before operation, and strenuous efforts were directed toward evacuation as soon as possible afterwards. From this extreme, the pendulum has swung to the entirely opposite view on the part of some surgeons, who proscribe the use of all cathartics before and after operation. For those who do not take this extreme view, the problem is one of finding cathartics in cases in which they are needed whose action is mild and yet effective.

Hence the present study was undertaken primarily to evaluate the action of sennosides A and B in preoperative and postoperative care, but was extended to nonsurgical patients. The group of 51 cases was a consecutive series, chosen as the patients presented themselves at the office or hospital. The surgical patients all had constipation postoperatively. The dosage in these patients was usually 2 tablets of glysennid (sennosides A and B) upon retiring, and in most cases this was effective. In a few cases, however, much larger doses were required. The nonsurgical patients received 1 tablet after the evening meal and 2 more at bedtime, and in all cases, this dosage was effective.

In the series there were 23 surgical patients, varying in age from 22 to 81 years, and 28 nonsurgical patients, whose ages varied from 20 to 82

years. There were no untoward effects from the glysennid in any instance.

The following case histories are illustrative of those in which large doses of glysennid were required.

Report of Cases

Case 1.—A woman, aged 51 years, had had a subtotal hysterectomy for fibroids of the uterus two years before she consulted me. After the operation, she had suffered from a manic-depressive psychosis, which was treated by three courses of electroshock therapy, with complete recovery from the mental illness. During this period, however, there had developed a severe constipation which persisted after her release from the hospital. In her case, 2 glysennid tablets four times a day are necessary to control the constipation.

Case 2.—A man, aged 69 years, suffering from a tumor in the anterior mediastinum, was prepared for operation over a period of six weeks, because he was a poor surgical risk. During this time, it was necessary to administer 2 tablets of glysennid three times a day in order to maintain adequate evacuation. At operation, a substernal thyroid was found. After operation, intestinal action was improved, and satisfactory evacuation was maintained with only 2 tablets of glysennid at bedtime.

Summary and Conclusions

A study of the results of administration of glysennid in 51 unselected cases, 23 surgical and 28 nonsurgical, showed that effective evacuation was maintained in all cases without untoward effects. In most instances, a dosage of 2 tablets at bedtime was sufficient, but in a few cases, much larger doses were required.

Contraindications to the use of glysennid are the same as for any other cathartic, namely, any obstructive or open lesion in the gastrointestinal tract.

It is concluded that glysennid is a useful addition to the medical armamentarium, particularly in postoperative atonic constipation and in constipation in the aged.

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ABSTRACTS OF MEDICAL ARTICLES

THE USE OF ANTICOAGULANTS IN ACUTE CORONARY INSUFFICIENCY OR IMPENDING MYOCARDIAL INFARCTION. By E. Sterling Nichol, M.D. South. M. J. 43:565-574 (July) 1950.

A series of 41 cases, all of which are individually summarized, is reported in which the patients were considered to be showing signs of threatened myocardial infarction or acute coronary insufficiency and were given heparin and dicumarol to ward off myocardial infarction. Frequently, relief of anginal pain was prompt and striking. Transmural myocardial infarction developed in only 2 patients. There were no deaths in the group while under treatment, but 4 patients died with the clinical diagnosis of acute coronary thrombosis one week to ten months after discontinuing anticoagulants.

Clinical signs of subendocardial necrosis developed in 24 of the patients. Long term dicumarol therapy was given 23 patients, 17 of whom were continuing on the regime in periods ranging up to eighty-two weeks.

The author reviewed comments in the literature referable to the possible use of anticoagulants in threatened myocardial infarction and pointed out the difficulties inherent in the distinction between threatened myocardial infarction and acute coronary insufficiency (Master) or coronary failure (Freedberg). He concluded that the results obtained justify an extensive trial of heparin and dicumarol in threatened myocardial infarction or acute coronary insufficiency even when a history of previous myocardial infarction is lacking.

CARCINOMA OF THE CORPUS UTERI. By Cayetano Panettiere, M.D. South. Surgeon 16:594-598 (June) 1950.

The purpose of this paper is to present the salient factors and views which enter into the recognition, diagnosis, and treatment of carcinoma of the corpus uteri. The author points out that carcinoma of the fundus, at first a localized endometrial growth, progresses by direct extension in the majority of cases and distant involvement is slow. The disease can be recognized early and effective treatment established. In contrast with carcinoma of the cervix, fundal carcinoma can be

attacked before distant metastases have occurred.

After discussing diagnosis, Dr. Panettiere deals with pathology and prognosis. He devotes a considerable portion of the paper to the histologic classification of fundal carcinoma, which is important because the prognosis and treatment bear a direct ratio to the histologic pattern.

He observes that abdominal complete hysterectomy with bilateral salpingo-oophorectomy is the treatment of choice, with some clinics preferring to combine this surgical procedure with irradiation. In his experience, the results of surgery alone have been striking, with five year survivals encouraging, when there is no evidence of extension of the disease beyond the local limits. The percentage of five year salvage markedly decreases, however, with extension of the disease, and in such cases intensive irradiation is advocated.

CERVICAL PREGNANCY. By Oren A. Ellingson, M.D., F.A.C.S. South. M. J. 43:962-964. (Nov.) 1950.

In the 3 cases reported, the most prominent symptom of cervical pregnancy was painless uterine bleeding in the first trimester of pregnancy, and the physical findings were limited to a large bulbous cervix with a smaller firm uterus above the cervical enlargement. The diagnosis was made by the finding of the pregnancy in the cervix with a tightly constricted isthmus above the implantation site, and a uterine cavity which contained only decidua without chorionic villi. Since in no case was there difficulty in evacuating the pregnancy from the cervix, apparently early fetal death and minimal cervical trophoblastic invasion had occurred.

The author concluded that cervical pregnancy in the first trimester may occur more commonly than is generally appreciated and that only by careful examination at the time of curettage can this entity be distinguished from that of uterine abortion. He observed that cervical pregnancy in which the trophoblastic invasion is minimal is not necessarily a serious complication of pregnancy.

FRACTURE OF THE SPINE, NEW TREATMENT WITHOUT PLASTER CASTS. By Eugene L. Jewett, M.D., F.I.C.S. J. Internal. Col. Surgeons 13:407-414 (April) 1950.

A method is described for treating compression fractures of the lower dorsal and lumbar portions of the spine without the use of plaster casts or hyperextension other than on a reversed Gatch bed. Neither general nor local anesthesia is employed, and the patient is usually ambulatory within a week or two after trauma. On the whole, the results have been excellent, the author reports. He presents data on 58 consecutive cases of compression fracture of the spine in which the patients, whose ages ranged from 7 to 85 years, were treated by this method.

DICUMAROL FATALITY IN SEVERE HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DESPITE CONTROLLED THERAPEUTIC LEVEL. By Rose E. London, M.D. Circulation 1:1205-1208 (May) 1950.

A case, with autopsy, is reported which illustrates the disastrous complications resulting from the use of dicumarol in spite of control at recommended therapeutic levels in an elderly patient with severe hypertensive and arteriosclerotic cardiovascular disease. Fatal widespread hemorrhage occurred despite prior use of the drug in identical dosage over a period of seven months without serious complications. The author points out that the case serves to emphasize the danger of a false sense of security in regard to patients treated with a dangerous drug over a long period of time.

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NOTICE

Your March Journal carried a complete program and other detailed information relative to the Seventy-Seventh Annual Meeting of the Association in Hollywood, April 22-25.

April Anniversaries

APRIL 1. William Harvey was born in Folkstone, England, on April 1, 1578. He was graduated in medicine at Cadua on April 25, 1602, and that same year received an M.D. degree from Cambridge University. Largely based on anatomic discoveries of his immediate predecessors, Harvey's "Circulation of the Blood," published at Frankfurt in 1628, had a far reaching effect on the development of medical science and served as the foundation for modern physiology. Harvey demonstrated circulation of the blood by planned experimentation and observation of the results. It has been aptly said that "his life was spent in hunting down truth in truth's own book."

APRIL 4. Dorothea Lynde Dix was born in Hampden, Maine, on April 4, 1802. During her early life she came under the influence of Dr. Channing, the famous Unitarian minister. Upon teaching a Sunday School class in a Boston jail in 1841, she found that the insane were confined "in cages, closets, stalls, pens; chained, naked, lashed." Never appearing in public, always gentle and reserved, Miss Dix spent the rest of her life accumulating unmistakable evidence of such institutional

horrors, and chose spokesmen to present that evidence to the public. As a direct result of her efforts thirty-two modern hospitals for the insane were founded.

APRIL 5. Joseph, Lord Lister was born on April 5, 1827. After receiving his medical degree in London, Dr. Lister studied surgery under the famous Dr. Syme in Edinburgh. Impressed by tragic results due to sepsis in surgery, Lister with great patience and devotion to detail showed that Pasteur's new teachings regarding bacteria were pertinent to surgical technic. In 1867, he reported to the British Medical Association, meeting in Dublin, his first experiments at Glasgow on the use of carbolic acid as an antiseptic. From Lister's "antiseptic surgery" it was only a short, natural step to modern aseptic surgery. Lord Lister proved to be the greatest of an inspiring line of Quakers who were distinguished in English Medicine. A study of his life shows that he was highly intelligent, had unusual strength of character, and displayed a friendly, even temperament.

APRIL 8. William Henry Welch, affectionately known as "Popsy," was born on April 8, 1850. He made important contributions to bacteriology, but probably more important, he was an inspired teacher. Many of the outstanding American pathologists of today were his devoted students at the Johns Hopkins University School of Medicine. Noted for his wisdom, down-to-earthness, and phenomenal memory, Popsy Welch found it difficult if not impossible to retire. Upon relinquishing the chair of pathology at the Hopkins

at 66 years of age, he was promptly drafted as director of the newly organized School of Hygiene and Public Health at that institution. When he attempted to retire again at the age of 76, he was given the newly established chair of the history of medicine at the Johns Hopkins. Until a relatively short time before his death on April 30, 1934, Dr. Welch served as consultant and advisor on problems in medical education and research to the universities and educational foundations of the entire nation.

APRIL 12. John Shaw Billings was born on April 12, 1838. Immediately after the War Between the States, he became librarian to the Library of the Surgeon General's Office in Washington, D. C. Responsible for making that medical library the best in the world, Dr. Billings with the assistance of Fielding H. Garrison and Robert Fletcher also produced the Index-Catalog of the Library of the Surgeon General's Office, a catalog of authors and subjects of all medical literature, and the Index Medicus, the well known monthly bibliographic catalog. These great works are living monuments to the man.

APRIL 21. Rome was supposedly founded on April 21, 753 B.C. At least that date is celebrated as Rome's birthday. Early Roman medicine consisted of treatment with native herbs and religious rites until Greek physicians were imported. The cult of Aesculapius was introduced with a huge serpent from Epidaurus during the plague of 293 B.C. Among Roman contributions to world medicine are sewers, aqueducts and public baths.

Civilian Defense: Its Psychiatric Aspects

The heart of civilian defense lies in medicine, the physicians who implement it, and the intricate network of auxiliary services which of necessity complement it. Too much depends upon an adequate and early state of medical preparedness for the physician to be other than wholly realistic about it. It is of course true that in times of disaster medical service does not differ greatly from that rendered every day, except in certain particulars. In catastrophic situations, the difficulties encountered in performance, the volume, the great overloading of available facilities and the sharp increase in certain types of injury all create problems to which there is no leisurely approach. Not the least of these is the mental hazard.

Florida with its 2,100 miles of coast line and its numerous critical target areas is highly vulner-

able to attack from submarine or bomber. Its citizens may well be bomb-conscious. How would they react in case of attack? How many would be mental casualties?

Under wartime bombing in England, panic was not the problem that had been anticipated. The English became accustomed to bombing. So did the Japanese; instead of seeking shelter they went about their work as usual—until the atom bomb was dropped. Thereafter, any light or spark remotely resembling the light flash of the explosion, any sound merely suggesting an airplane sent them bolting for shelter. They were unable to sleep, eat or work.

Prevention of panic begins before disaster strikes with adequate shelters and education of the public. Education, however, must be discreet and should include a master plan to help each person find an active place in the defense, lest it actually create the panic it would avoid.

After disaster strikes, first aid in prevention of panic is a known source of reliable information—perhaps sound trucks or small planes with loud speakers.

A Los Angeles psychiatrist¹ recently made constructive suggestions for strengthening morale in a bombed area. Among them were trailer first aid stations equipped for emergency treatment of mental casualties, mobile laundry units to provide clothing free of glass, splinters and contamination with radioactive materials, and mobile kitchens with the hot food which is proven medicine against shakiness. He emphasized the importance of uniformed civilian defense members appearing on the scene as quickly as possible, for the mere presence of a person in authority is often enough to create confidence. He also advocated careful advance planning of evacuation of children, preferably to relatives or friends in safe areas already familiar to them, since in the last war psychiatric disturbance among evacuated children exceeded that of children in bombed areas. Likewise, care of the aged should be well planned in advance for their reluctance to move and their slowness handicap rescue operations.

Florida not only has its own critical target areas but it also has a supporting role as a likely evacuation reception center for neighboring states. It can ill afford, therefore, to lag in civilian defense measures. It should, and no doubt will, be in the vanguard of states in this movement with the members of the Florida Medical Association

in the forefront among cooperating agencies. Every member of the Association should be ever mindful that "civilian defense means YOU!"

1. Fantl, K.: Psychiatric Aspects of Civilian Defense, *Am. J. Psychiat.* 107:488-492 (Jan.) 1951.

Activities of the Ford Foundation

The Ford Foundation is now beginning to put its multimillion dollar resources to work for world peace and better governmental, educational and living conditions. Endowed by the Henry Ford family, it has assets estimated at \$250,000,000. They are being used to support studies, research and other activities on human needs which are primarily social rather than physical in character.

The trustees, headed by Henry Ford II, have chosen five areas for action. The first is world peace and the establishment of a world order of law and justice. The others are greater allegiance to the basic principles of freedom and democracy, economic well-being of people everywhere, educational improvements and scientific knowledge on human conduct.

The last of these areas has particular interest for the medical profession because of its bearing on psychosomatic medicine. Scientific knowledge on human conduct means research on human behavior, including causes and cures of "personal maladjustment, neurosis, delinquency and crime." The plans for exploration of this area suggest the assertion made some years ago by H. G. Wells in his *History of the World*: "It is scarcely an exaggeration to say that at present mankind as a species is demented and that nothing is so urgent upon us as the recovery of mental self-control." Surely in this chaotic day, nations as well as individuals need urgently to cultivate the restraints inherent in mental self control.

This great philanthropic endeavor with its fivefold objective is, to say the least, a worthy undertaking which merits commendation and encouragement from the world's citizenry as it battles for a free world and a better life for all.

Therapeutics*

(With Appropriate Apologies)

Open your therapeutics — study a page or two,
'Twill benefit your patient and it may be good for you.

Much you read is inapropos, more is good by far:
Consider the subject matter, take the best at par.

It may be an ancient issue, it might be a late edition;

Fortify your mind with facts and better your patient's condition.

Study physiologic actions, apply therapeutic tests,
Rely on good authority, expect results with zest.

Physiologic actions vary, therapeutics causes suspense;

Idiosyncrasies considered, use common sense.

Do not blame the drug if the patient is not improving,

Consider your diagnosis, errors may need removing.

Open your therapeutics, all covered with dust and brown;

Peruse its pages early and after the sun goes down.

Such perusal will give you comfort, perhaps will give you rest,

When the patient is quietly sleeping from a therapeutic test.

Many a doctor has floundered on the rocks of proprietaries,

Swallowing "hook, line and sinker" of the detail luminaries. . . .

Let each and every ingredient stand the test of science;

Study your therapeutics for that's the best reliance.

It's elixir this, and elixir that, and syrups forty or more,

Many extracts, cure-all tonics and mixtures by the score.

Of incompatible, inert drugs, antagonists and junk;
Of sedatives and concoctions all of which are punk. . . .

The detail man has a thing to sell, he has a wage to earn,

He's paid to talk his line of goods, but has a lot to learn.

Treat him kindly, courteously, thank him for his toil,
But review your therapeutics and "burn the mid-night oil."

Open your therapeutics and read its pages through,
Here's a potent alkaloid and several sera too.

Which is the better agent, concoctions of many kinds

Or a number of active principles, fifty kept in mind?

Councillors active and potent, comforters helpful,
true;

And never a one of the fifty to negative the faith
in you.

Use them with discretion, from all select a few,
If diagnosis is correct, they'll aid and comfort you.

Sinnig Mac.

*Written many years ago by the late Dr. R. H. McGinnis, who at the time of his death in December 1949 was the oldest past president of the Florida Medical Association.

Graduate Short Course

June 25-30, 1951

The Nineteenth Annual Graduate Short Course will be held in Jacksonville at the George Washington Hotel the week of June 25-30, inclusive. As has been the policy for these many years, the best available teachers in the various fields will deliver the lectures. In addition to the lectures on Medicine, Pediatrics, Obstetrics, Surgery and Gynecology there will be five lectures on Diseases of the Chest and one evening lecture on Poliomyelitis.

Dr. Chester S. Keefer, Wade Professor of Medicine, Boston University School of Medicine, will again present the lectures on Medicine. His talks will cover a discussion of pain, antibiotics, cortisone with further observations, management of patients with heart failure and other subjects.

Dr. S. F. Ravenel, Dean of the Southern Pediatric Seminar at Saluda, N. C., will return as the guest lecturer on Pediatrics.

Dr. William J. Dieckmann, Professor of Obstetrics and Gynecology, University of Chicago, The School of Medicine, and Chicago Lying-In Hospital, will hold informal sessions on Obstetrics, answering questions submitted in advance as well as those from the floor.

Dr. David T. Smith, Professor of Bacteriology and Associate Professor of Medicine, Duke Uni-

versity School of Medicine, has consented to deliver five lectures on Diseases of the Chest. These lectures will cover tuberculosis, fungus diseases of the lungs, and bacterial and viral infections of the lungs.

Dr. Robert J. Neville, Director of Orthopedic Services of the National Foundation for Infantile Paralysis, New York, will present an evening lecture on Poliomyelitis, discussing the recent advances and treatment. This disease is on the increase both in incidence and geographic distribution and therefore deserves a place in postgraduate medical education.

Dr. William A. Altemeier, Assistant Professor of Surgery, University of Cincinnati College of Medicine, will deliver the lectures on Surgery.

Dr. Andrew A. Marchetti, Professor and Chairman of the Department of Obstetrics and Gynecology, Georgetown University School of Medicine, will return as lecturer on Gynecology. Among the subjects he will discuss are management of uterine malpositions, problems of infertility and sterility, and carcinoma of the cervix.

Medical Licenses Granted

Dr. Homer L. Pearson, Jr., Secretary of the State Board of Medical Examiners, has reported that of the 150 applicants who took the examination of the Board, held November 26, 27 and 28, 1950 in Jacksonville, 116 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 116 successful applicants follow:

Alexander, Robert Martin, Lake City (Tulane U. 1944)
Andrews, Doddridge Lee, Noblesville, Ind. (Indiana U. 1938)
Angel, Norman Sol, Chicago, Ill. (Chicago Med. Sch. 1938)
Badillo, Ramon, Miami (U. of Louisville 1950)
Balg, Joseph, Miami Beach (St. Louis U. 1930)
Bechtel, Jack Townsend, West Palm Beach (Emory U. 1950)
Bleakney, Rex Mitchell, Orlando (Ohio State U. 1945)
Braun, David Carl, Newton, N. J. (Georgetown U. 1928)
Brown, Clyde MacKenzie, Tampa (U. of Western Ontario 1943)
Cason, Margaret Louise, Durham, N. C. (U. of Chicago 1950)
Chambers, Frank, Jr., Plant City (U. of Buffalo 1950)
Chesney, John George, South Miami (Cornell U. 1942)
Cimino, Louis Eugene, Tampa (St. Louis U. 1950)
Clark, Clyde Eugene, Lakeland (U. of Michigan 1935)
Cole, Benjamin McDowell, Orlando (Med. Coll. State of S.C. 1950)
Cowdery, John Stewart, Orange Park (Temple U. 1943)
Cowdery, Patricia Collins, Orange Park (Temple U. 1948)
Crane, David Lawrence, Miami (U. of Louisville 1950)
Crouch, Carroll Marion, Orlando (Med. Coll. State of S.C. 1950)
Davis, Harold E., Miami (Northwestern U. 1926)

- Davis, James Dean (Col.), Tampa (Howard U. 1945)
 Dennehy, William James, New Haven, Conn. (Yale U. 1918)
 DuBose, Howard McRoy, Chamblee, Ga. (Duke U. 1949)
 Edwards, Albert Thomas (Col.), St. Louis, Mo. (Meharry 1950)
 Failmezger, Theodore Richard, Madison, N. J. (Jefferson 1934)
 Falcone, Alfred Eugene, Miami (U. of Buffalo 1950)
 Feit, Louis Joel, Cassadaga (N. Y. Med. Coll. & Flower Hosp. 1934)
 Ferayorni, Richard Rudolph, West Palm Beach (Long Island Coll. Med. 1943)
 Fox, Leonard, Wyandotte, Mich. (U. of Michigan 1945)
 Frymark, William Bernard, River Forest, Ill. (Marquette U. 1946)
 Gambrell, William Mooney, Jr., Miami (U. of Texas 1950)
 Gary, Edward Thomas, Coral Gables (George Washington 1931)
 Glenn, Leland Kirk, Kannapolis, N. C. (Bowman Gray Sch. Med. 1948)
 Goldstein, Samuel J., Miami (Ohio State U. 1929)
 Gundel, Robert Ellsworth, Tampa (U. of Penn. 1945)
 Gutsell, Robert S., Chattahoochee (U. of Minnesota 1921)
 Hadden, Shirley Louis, Pompano Beach (U. of Illinois 1925)
 Halperin, Bernard, Miami (Chicago Med. Sch. 1950)
 Harvey, Robert Arthur, Cleveland, Ohio (Western Reserve U. 1946)
 Hendrix, Joseph Paul, Frisco City, Ala. (Emory U. 1949)
 Herman, Melvin Jerome, Miami (Chicago Med. Sch. 1946)
 Herron, Carroll Vincent, Daytona Beach (Tulane U. 1945)
 Hicks, Lawrence (Col.), Pensacola (Meharry 1950)
 Hodkin, Samuel Jerry, Elmhurst, N. Y. (Eclectic Med. Coll., Cincinnati 1925)
 Irwin, Richard Maris, Avondale, Pa. (Hahnemann Med. Coll. of Phila. 1943)
 Jacobson, Sherwood Arthur, Sanford (Tulane U. 1948)
 Jamison, King Arcy, Miami (U. of Virginia 1943)
 Jaslow, Albert C., Miami (Wayne U. 1950)
 Johnson, Lawrence Wayne, St. Petersburg (Northwestern U. 1947)
 Johnston, Harold Wilkes, Neptune Beach (Bowman Gray Sch. Med. 1943)
 Jones, Millard Filmore, Richmond, Va. (Temple U. 1940)
 Juers, Arthur L., Miami (U. of Louisville 1931)
 Kaufman, Jacob, St. Augustine (Coll. of P. & S., Boston)
 Kearns, Walter M., Milwaukee, Wis. (Marquette U. 1921)
 Khoury, Albert John, Gainesville (Mexico 1948)
 King, Samuel Augustus, Hollywood (Med. Coll. of Georgia 1950)
 LaCour, Bennett Joseph, Jr., Monroe, La. (Louisiana State U. 1939)
 Lammert, Albert Charles, Jacksonville (Western Reserve U. 1948)
 LaRue, Raymond Abram, Miami (Albany Med. Coll. 1949)
 Loseff, Herbert S., Chicago, Ill. (U. of Illinois 1945)
 McCorkle, Walter Woodfin, Gadsden, Ala. (Vanderbilt U. 1944)
 McDowell, Richard Wendel, Jacksonville (U. of Penn. 1947)
 McIntosh, Henry Deane, Durham, N. C. (U. of Penn. 1950)
 McShane, James K., Jr., Coral Gables (Georgetown U. 1950)
 McSwain, George H., Durham, N. C. (Vanderbilt U. 1941)
 Madden, Edward Patrick, Daytona Beach (Loyola U. 1930)
 Manry, Willard E., Jr., Jacksonville (Tulane U. 1950)
 Maxwell, Clarence Jay, Coral Gables (Ohio State U. 1927)
 Mays, Joseph Lamar, Jackson, Ga. (Emory U. 1947)
 Meyers, Wilford Dwight, Takoma Park, Md. (Coll. Med. Evangelists 1949)
 Moran, John Edward, Greenfield, Mass. (U. of Maryland 1927)
 Murphy, George Marion, Franklin, Ind. (U. of Indiana 1945)
 Norton, James Osmore, Dunedin (Creighton U. 1950)
 Novell, Howard Andrew, Daytona Beach (Ohio State U. 1948)
 Ovitiz, Morris, New York, N. Y. (Coll. of P. & S., Boston 1947)
 Pacetti, William Augustin, Jr., Miami (Tulane U. 1950)
 Parrish, Carrol Ernest, Chattahoochee (Coll. Med. Evangelists 1938)
 Perez, Carlos Andres, Tampa (U. of Havana, U. of Indiana 1943)
 Pope, Charles Lytton, Harlan, Ky. (Vanderbilt U. 1945)
 Ragsdale, Milton Clay, III, Bessemer, Ala. (Harvard U. 1945)
 Raybin, George Israel, Jacksonville (Long Island Coll. Med. 1943)
 Reed, Paul Allen, Washington, D. C. (U. of Iowa 1939)
 Reinstine, Harry Wampole, Jr., Jacksonville (U. of Virginia 1949)
 Ridge, John Clinton, Miami (St. Louis U. 1950)
 Roberts, Isabel, Melbourne (Women's Med. Coll. of Penn. 1939)
 Ross, Perry W., Chicago, Ill. (U. of Illinois 1930)
 Rosser, Robert Guthrie, Jr., Jacksonville (Med. Coll. of S. C. 1943)
 Roy, Robert Leo, Washington, D. C. (Georgetown U. 1944)
 Russman, Howard Bruno, Miami (U. of Illinois 1947)
 Samartino, Gaetano Thomas, Tampa (State U. of New York 1950)
 Safian, Leroy Scheller, Orlando (Med. Coll. of Virginia 1943)
 Sayre, Bernard Edward, Chicago, Ill. (U. of Illinois 1924)
 Schofield, Hampton Lee, Jr., Orlando (Med. Coll. State of S. C. 1950)
 Schwarcz, Benjamin Edward, Miami (Loyola U. 1931)
 Schwartz, Stanley Eugene, Flushing, N. Y. (U. of Maryland 1941)
 Seltam, Jack Harold, New Orleans, La. (Northwestern U. 1950)
 Siegel, Louis, Bronx, N. Y. (Middlesex U. 1943)
 Silberman, Charles George, Miami (Jefferson Med. Coll. 1950)
 Silverstone, Eugene Henry, Coral Gables (U. of Illinois 1931)
 Sims, Myrl David, Oak Park, Ill. (U. of Illinois 1949)
 Smith, Edward Rousseau, Jacksonville (Vanderbilt U. 1949)
 Smith, James Ronald, Fort Worth, Texas (U. of Oklahoma 1944)
 Stanton, Arnold, Richmond Hill, N. Y. (Long Island Med. Coll. 1930)
 Stewart, John Siegfried, St. Petersburg (Temple U. 1943)
 Stinger, Naomi Thompson, Panama City (U. of Pittsburgh 1948)
 Strasser, Hans Adrian, Gainesville (Columbia U. Coll. P. & S. 1935)
 Sturm, Frederick George, Miami (Wayne U. 1950)
 Tager, Stephen N., Urbana, Ill. (Germany 1935)
 Taliaferro, Harry Francis (Col.), Tampa (Howard U. 1948)
 Terry, John Heaney, Galesburg, Ill. (Tulane U. 1949)
 Thomas, Joseph Edward, Miami (Georgetown U. 1948)
 Vaughn, Phyllis Peterson, Miami (U. of Maryland 1948)
 Wadsworth, Charles Lawrence, Cincinnati, Ohio (U. of Cincinnati 1943)

Wallace, Paul Fleugel, St. Petersburg (U. of Chicago 1944)

Ward, Edwin St. John, Penney Farms (Columbia U. Coll. P. & S. 1904)

Wikler, Irving, Fort McPherson, Ga. (Ohio State U. 1948)

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bailey, Walter H., St. Petersburg

Benton, John J., Panama City

Boyle, John P., St. Petersburg

Brown, Charles A., Daytona Beach

Canakaris, John M., Bunnell

Cohen, Elliott C., Miami Beach

Croft, George W., Jacksonville

Ferrer, Nicanor, Miami

Finch, Thomas V., Sarasota

Frell, Thomas C., Hialeah

Grayson, Robert J., Miami Beach

Guiteras, George G., Gainesville

Hoare, Francis C., Clearwater

Hopkins, George C., St. Augustine

Humphreys, William F., Jr., Panama City

Katzman, Joseph D., Miami Beach

Ketchum, Clarence W., Tallahassee

Langer, Edward M., Sarasota

Lipton, Simon M., Miami

Ludwig, Edward W., Jacksonville

Massey, Bennie J., Palatka

Medoff, Lawrence R., Miami

Novak, Louis J., Hollywood

Pararo, Luther L., Jr., Tallahassee

Patterson, Joseph F., Jr., Sarasota

Pearlman, Saul J., Miami

Plucinski, Stanley J., Miami Shores

Rhodes, George M., Jr., Fort Lauderdale

Rothrock, David R., Chattahoochee

Rowe, David L., Fort Pierce

Starke, Lancaster C., (Col.), DeLand

Stewart, John S., Fort Myers

Swift, Walker E., Sarasota

Toth, Alexander G., Jr., Miami

Valentine, Frank, DeLand

Wallace, A. Wm., Coral Gables

Wilkins, Charlotte K., North Miami

Zinn, Charles J., Gainesville

STATE BOARD OF HEALTH

Announcements of Births Registered by the Bureau of Vital Statistics

The births of the following were recently officially recorded by the Bureau of Vital Statistics of the State Board of Health:

Sports Model Higginbotham

Full Dress Coat

Merry Christmas Olsen

Vaseline Lewis

Earthie Clay and Potter Clay (twins)

Cigar Stubbs

Wedless Souvenir Campbell

Public Joy Mitchell

Little Man Hicks

Usay Nelson

Peek-a-boo Riggins

Twinkle Star Gibbs

Physicians are urged to fill out birth certificates and forward them promptly because these are required for many purposes. At the present time many persons are having difficulty in volunteering or in obtaining commissions in the Armed Forces because of the lack of a birth certificate proving their age or citizenship. Attention is also called to the fact that one must be able to prove himself a citizen and have reached a certain age before he can become president of the United States. None of the above persons will ever be handicapped because of the lack of this vital evidence. Their family physician, local registrars and parents are to be congratulated for promptly recording their births.

YOUR BLUE SHIELD

Annual Blue Shield Meeting

The annual meeting of active members of the Florida Medical Service Corporation will be held on Sunday, April 22, 1951, at 10:00 a.m. at the Hollywood Beach Hotel, Hollywood, Florida, in conjunction with the annual meeting of the Florida Medical Association.

This is the opportunity for Blue Shield physicians to learn first-hand the problems and activities of their plan, and to have a voice in the affairs of the corporation.

Election of Directors

At the annual meeting, elections are to be held for directors of the corporation to fill the vacancies on the Board brought about by the expiration of several terms of office.

According to the By-Laws of the Florida Medical Service Corporation, the Board of Directors shall consist of eighteen directors, chosen as follows: two participating doctors from each medical district of the Florida Medical Association; two or more participating doctors from the Florida Medical Association's membership at large, and one or more laymen from each medical district of the Florida Medical Association. All directors are elected by the active members of the corporation and serve for a period of three years each. At the first annual meeting of the corporation directors were elected to serve for terms of one, two and three years in order that an equal number of terms would expire each year thereafter.

Active Membership

It is not too late for participating physicians who are not now active members to make application to the plan to serve in this capacity, and thereby become eligible to attend the annual meeting. Active membership requires that no dues be paid and does not obligate the physician in any way.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Maxwell M. Sayet of Miami Beach announce the birth of a daughter, Katherine Alison.
Dr. and Mrs. Joseph T. Jana, Jr., of Miami announce the birth of a son, Joseph T., III.
Dr. and Mrs. Philip M. Greenberg of Miami Beach announce the birth of a daughter, Marian Lela.
Dr. and Mrs. James B. O'Connor of Jacksonville announce the birth of a son on Feb. 14, 1951.

Marriages

Dr. Richard M. Fleming and Mrs. Colman Zwitman, both of Miami, were married on Jan. 31, 1951.

Deaths — Members

Oertel, Henry B., Kissimmee	Dec. 12, 1950
Williamson, Jos. P., Winter Park	Jan. 2, 1951
Estes, James L., Tampa	Jan. 10, 1951

Deaths — Other Doctors

Myres, M. J., Shreveport, La.	Nov. 30, 1950
Harsha, William T., South Miami	Dec. 15, 1950
Weeks, James L., Perry	Jan. 30, 1951
Airth, Henry F., Live Oak	Jan. 31, 1951
Timberlake, Gideon, St. Petersburg	March 1, 1951
White, Jacob A., Tampa (Col.)	Nov. 17, 1949
Anderson, James J., Jacksonville	March 8, 1951

STATE NEWS ITEMS

President Herbert E. White of St. Augustine has returned to his practice following a brief visit to Miami where he conferred with Association members and visited local hospitals.

Drs. Ashbel C. Williams and Frank G. Slaughter of Jacksonville were guest speakers at a recent meeting of the Duval County Council of Parents and Teachers. Dr. Williams' talk dealt with cancer. Dr. Slaughter spoke on the child's place in his community.

Dr. Howard A. Engle of Miami Beach has been honored by the State Junior Chamber of Commerce as one of the five outstanding young men in Florida. Dr. Engle was recognized by the Jaycees for his work in the diagnosis of congenital heart defects.

Dr. S. Carnes Harvard of Brooksville was the featured speaker on February 5 in the first of a series of programs arranged by the Hernando County Civil Defense Organization. Dr. Harvard chose as his subject, "What the Public Should Know to Combat a Germ War."

Dr. John T. Stage of Jacksonville was the guest speaker at the January meeting of the county medical society at Columbus, Georgia.

Dr. Herbert L. Bryans of Pensacola has been elected president of the State Board of Health for the tenth consecutive year.

Dr. Andrew P. Haynal of Orlando has left the medical staff of the Florida Sanitarium to attend a special three months course at the Harvard University School of Public Health. Upon completion of the course Dr. Haynal will join the Economic Cooperation Administration for public health work in southeast Asia.

Dr. J. Sudler Hood of Clearwater recently appeared before the local Rotary Club to explain to the members the difficulty doctors have in keeping up with all the advancements in medicine.

Programs for all postgraduate medical education courses are mailed through the courtesy of the State Board of Health along with its monthly blotters, which arrive on the desk of every physician in the state the first of each month. Many physicians have not been receiving their programs for these courses. It is suggested that the secretaries be notified to open all such correspondence and make a point of saving these programs for the future reference of the doctor. Also read The Journal for advance notices of these courses.

At the Nineteenth Annual Graduate Short Course, to be held in Jacksonville the week of June 25-30 inclusive, an experiment will be conducted in the presentation of the lectures on Obstetrics. Dr. William J. Dieckmann, Professor of Obstetrics and Gynecology at the University of Chicago, The School of Medicine, and Chicago Lying-In Hospital, has asked that he be allowed to give informal lectures based on questions submitted in advance as well as to answer questions from the floor when time permits. He requests that physicians send in questions as soon as possible so that he may prepare a general outline and slides. He has expressed the belief that in this way he can best cover the subject to the satisfaction of those attending. The physicians who attended the Postgraduate Course in Obstetrics, held in Jacksonville on Oct. 23-25, 1950, will remember Dr. Dieckmann's excellent teaching and handling of informal sessions. Please address all questions to the office of the Department of Medicine, Graduate School, University of Florida, 1009 Stockton St., Jacksonville 4.

Dr. Kenneth G. Gould of Tampa headed the speakers division of the Tampa Heart Association in connection with the 1951 heart fund campaign during February.

Dr. William H. McCullagh of Jacksonville recently spoke to the local Pilot Club on mental health and the causes, effects and cures of nervousness.

Dr. Elwyn Evans of Orlando was the guest speaker at the opening meeting of the Orange County Heart Association drive.

Dr. John D. Cross of DeLand has recently opened offices in that city for the practice of medicine.

Dr. Gary E. Turner of Jacksonville addressed the February meeting of the beaches branch of the American Association of University Women.

Dr. Edward R. Annis of Miami chose the subject, "Time for Re-Awakening," at a dinner meeting held at the Republican Headquarters Club on February 20.

Dr. Donald G. Bradshaw of Zephyrhills has been attending medical meetings and visiting hospitals in several eastern and middle west states.

Dr. William J. Phelan of Jacksonville was the guest speaker at a recent meeting for registered nurses on the subject of "The Blood Procurement Program as Related to Civil Defense."

Dr. David R. Murphey, Jr., of Tampa, president-elect, was the guest speaker at the regular February meeting of the Polk County Medical Society.

Dr. Nelson Zivitz of Miami Beach, on February 2, read a paper before the New York University Postgraduate Medical School at the University Hospital in New York.

Dr. Duncan T. McEwan of Orlando spoke on "Socialized Medicine" at a meeting of the Contemporary Club of Lakeland in February. Dr. McEwan pointed out the probable decrease in quality of medical care under a compulsory insurance program and the excessive cost which would fall most heavily on the middle income group.

Col. William L. Wilson, United States Army Medical Corps, has been appointed Assistant Administrator for Health and Welfare of the Civil Defense Administration. For the past two years Col. Wilson has been special assistant to the Surgeon General of the U. S. Army for Civil Health Affairs.

Col. Wilson addressed the Seventy-Sixth Annual Meeting of the Association at Hollywood on April 25, 1950 on "Medical Planning for Atomic Disaster." Subsequent publication of Col. Wilson's article in the October Journal has brought wide professional and public acclaim.

Lt. W. Harold Parham who has been Supervisor of the Bureau of Public Relations for the past one and one-half years has been recalled to active duty. Lt. Parham left his Association activities on March 8 to report for duty at Washington, D. C. for further assignment.

The Orlando Medical Study Club had as its guest speakers on January 18, Dr. T. C. Davison, Atlanta, president of the American Goiter Association, and Dr. Adrian Verbrugghen, Chicago, Professor of Neurosurgery at the University of Illinois.

Dr. J. Rocher Chappell, chairman of the Committee on Advisory to Selective Service for Physicians and Allied Specialists called a meeting of the Committee at the Seminole Hotel, Jacksonville, Sunday, February 18. Members of this Committee in attendance were Drs. Chappell, John E. Maines, Jr., Gainesville, Alvin L. Mills, St. Petersburg, and Donald W. Smith, Miami.

In order to make available the latest information to the various interested groups throughout the state, Dr. Chappell invited representatives of county medical societies, dentists and veterinarians. Present to answer questions relative to selective service were Col. Robert G. White, St. Augustine, Deputy Director, Col. L. Holmes Ginn, Ft. McPherson, Ga., Staff Surgeon, Commanding General Third Army, and Lt. Col. Harold C. Wahl, St. Augustine, in charge of manpower for the state of Florida.

In attendance at this meeting were 34 doctors of medicine, 27 dentists and 4 veterinarians.

COMPONENT SOCIETY NOTES

Alachua

The Alachua County Medical Society in February met in a joint meeting with the newly formed Retail Pharmacists Association. The meeting was presided over by Dr. James N. McClamroch, president of the county medical society.

Dade

At the regular monthly meeting of the Dade County Medical Association, which was held on March 6, Dr. Willis E. Brown, Professor and Head of the Department of Obstetrics and Gynecology, University of Arkansas School of Medicine, presented a paper on "The Management of the Borderline Pelvis."

Duval

Guest speaker at the regular monthly meeting of the Duval County Medical Society on March 6 was Dr. E. L. Frazell, Memorial Hospital, New York City, who spoke on "Surgical Treatment for Cancer of the Mouth."

At a special meeting on March 13, the county society joined with the staff of St. Luke's Hospital to hear an address on "ACTH and Cortisone," by Dr. McGehee Harvey, Professor of Medicine, Johns Hopkins University.

DeSoto-Hardee-Highlands-Glades

The DeSoto-Hardee-Highlands-Glades County Medical Society held its regular February meeting at the Walker Memorial Hospital and Sanatorium in Avon Park. Guest speakers at the meeting were Dr. Joseph C. Hayward of Orlando, who presented a paper on "Common Causes for Unsatisfactory Results Following Endoscopic Prostatic Resection," and Dr. James B. Glanton of Orlando, who presented a paper on "Pediatric Urological Surgery."

Marion

The Marion County Medical Society on February 20 met at the Marion Hotel in Ocala. Dr. Leroy H. Oetjen of Leesburg gave an informal discussion on aviation medicine based on his experiences in World War II.

Members present were Drs. William H. Anderson, Jr., Hugh H. Barfield, John J. Cheleden, Bertrand F. Drake, John D. Lindner, Eaton G. Lindner, William J. McGovern, Carl S. Lytle, John N. Moore, Eugene G. Peek, Jr., and Jack M. Waldrep.

Nassau

All members of the Nassau County Medical Society have paid their 1951 state dues.

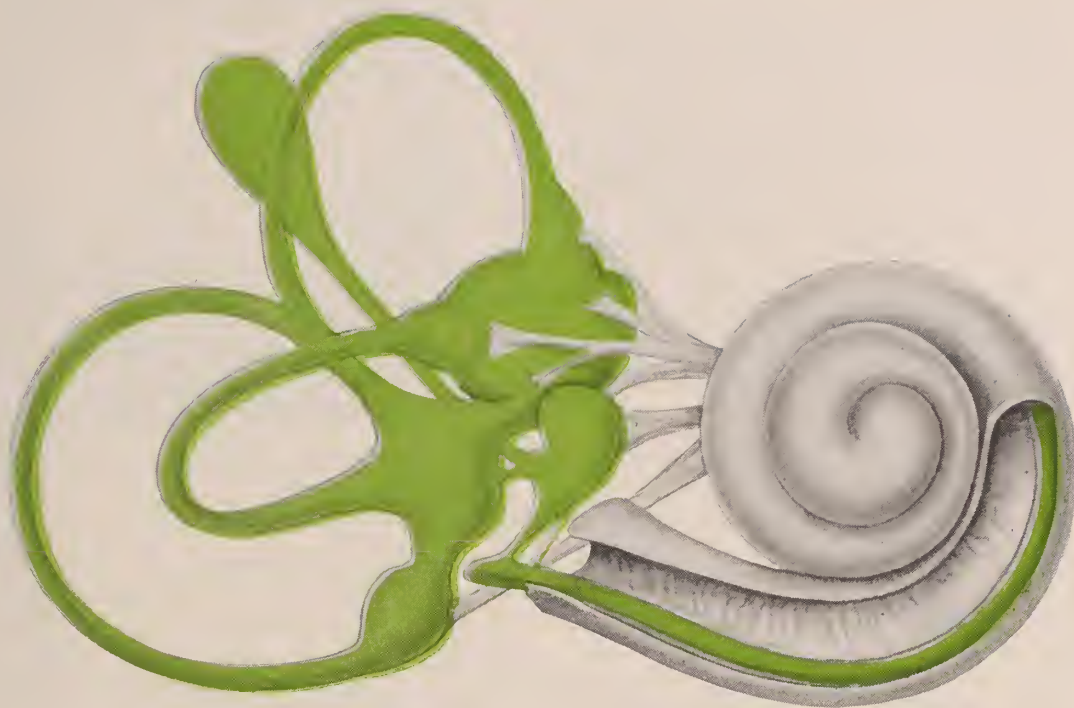
Pinellas

The Pinellas County Medical Society scheduled "Reminiscences" for its regular monthly meeting on March 5. This program was in charge of Drs. William M. Davis, Roscoe H. Knowlton and Alvin J. Wood, all of St. Petersburg.

Guest speaker at the symposium on tuberculosis held at the regular meeting in February was Dr. Henry C. Sweany, chief medical director of the state tuberculosis board.

Polk

The Polk County Medical Society, at its regular February meeting, held a discussion on the handling of emergencies which may arise during military or civilian disasters.



Detail of the Labyrinthine Structure

"The prophylactic value of Dramamine was conclusively demonstrated among 170 passengers who volunteered the information that they were unusually susceptible to motion sickness. . . . There was complete relief (freedom from any signs or symptoms of airsickness) in 152 cases or 89.5 per cent;"

—Tuttle, A. D.: *Special Breakdown of Case Histories*, presented at the Airlines Medical Directors Association Meeting, New York, N. Y., Aug. 28, 1949.

DRAMAMINE[®] Brand of Dimenhydrinate

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When for a physical or psychologic reason, the physician decides to depend on a spermatocidal jelly to protect the patient, he cannot do better than prescribe the "RAMSES"* Vaginal Jelly† Set No. 3.

Used as directed, the plastic applicator deposits 5 cc. of "RAMSES" Vaginal Jelly over the cervical os.

The cohesive and adherent properties of "RAMSES" Vaginal Jelly are of such high degree that the cervix remains occluded for as long as ten hours after coitus. "RAMSES" Vaginal Jelly, with its adjusted melting point, is not excessively lubricating or liquefying. "RAMSES" Vaginal Jelly exceeds the minimum spermatocidal requirement of the Council on Pharmacy and Chemistry of the American Medical Association.

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Photo taken after insertion of "RAMSES" Vaginal Jelly. Os occluded.



Photo taken ten hours after coitus. Occlusion still manifest.

Jelly stained with nonspermatocidal concentration of methylene blue for photographic purposes.

Dr. David R. Murphey, Jr., of Tampa, president-elect of the Florida Medical Association, was the guest speaker. Also on the program was Mrs. James L. Anderson of Coral Gables, president of the Woman's Auxiliary to the Florida Medical Association.

Suwannee

Dr. John N. Sims, Sr., of Live Oak has been elected president of the Suwannee County Medical Society replacing Dr. Irby H. Black of Live Oak, who resigned due to ill health.

OBITUARIES

Robert Fain Godard

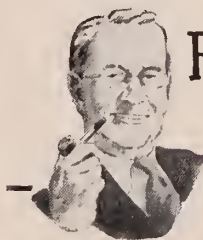
Dr. Robert Fain Godard of Quincy died in the Gadsden County Hospital on Nov. 3, 1950 at the age of 74 years. Although in ill health for several months, he had continued to engage actively in the practice of medicine until a few weeks before his death.

The son of a Baptist minister, Dr. Godard was born at Milner, Ga., on June 19, 1876. He attended Gordon Institute and received the degree of Doctor of Medicine from the University of Georgia School of Medicine in Augusta in 1900.

Upon graduation, he entered the practice of medicine at Citra and two years later became chief physician at the Florida State Hospital for a period of two years. Thereafter he was one of three special medical officers with the Florida State Board of Health under the late Dr. J. Y. Porter until 1906. At that time he began the long and successful practice of his profession in Quincy, where he had resided since 1903. Many years ago, his was a leading role in the establishment of the Gadsden County Hospital in that city. Locally, he was a Mason and a member of the American Legion, having served in World War I. He was a staunch member and hard worker in the Baptist Church, serving as a deacon and a Sunday School teacher.

Dr. Godard was a member of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, which he had been active in founding. He held membership in the Florida Medical Association for forty-five years and had for ten years been a life member. He was also a member of the American Medical Association.

Advertisement



From where I sit by Joe Marsh

Right Under Our Nose!

Sometime back, we got word from the Governor, asking if we wanted to use the State Fire Inspection Team—a group of experts they send around to inspect public buildings.

Wesent a letter saying: "Okay! Give us the once-over!" They came down, all right—last week.

After the inspection, we got their report. Came out pretty well. Town Hall and the School were O.K. Post Office just needed more sandbuckets. In fact, everything got a clean bill of health, except—the Fire Station!

From where I sit, we volunteer firemen had just been too blamed busy keeping *everyone else* on the ball—to realize our own firehouse was not up to snuff. We were like those people who worry so much about the other fellow's business—whether he can really afford that new car, how or where he should follow his profession, why he likes a glass of beer—that they forget to take a good critical look at themselves!

Joe Marsh

Naturally Good!



**the Ice Cream with
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Better tasting—better for you. Wholesome, nutritious, Southern Dairies Sealtest Ice Cream is the South's favorite. Try a delicious serving tonight.



In 1906, Dr. Godard married the former Susie Furlow Davis of Quincy, who survives him. Also surviving are a son, J. Davis Godard of Rome, Ga.; two daughters, Mrs. T. W. Conely of Okeechobee and Mrs. Charles M. Williams of Savannah, Ga.; a sister, Mrs. J. C. Means of Comer, Ga.; and a brother, the Reverend George D. Godard of Milner, Ga.

Leon Stanley Lippincott

Dr. Leon S. Lippincott of Daytona Beach died unexpectedly of a pulmonary embolus on Nov. 25, 1950. He was 62 years of age.

Born in Augusta, Me., in 1888, Dr. Lippincott received his academic degree in 1910 and his medical degree in 1913 from Bowdoin College, Brunswick-Portland, in his native state. From 1913 to 1917 he held the post of Instructor and Assistant Professor of Pathology and Bacteriology in the Medical School of his alma mater. He then served for two years during World War I in the Army Medical Corps, ending his military career as a major and chief of laboratory service, Base Hospital 72 overseas.

After the war, Dr. Lippincott located in Vicksburg, Miss., where he was pathologist for the Vicksburg Sanatorium from 1919 to 1942. During the second World War, he returned to Maine and served as pathologist for the Eastern Maine General Hospital at Bangor for five years. In 1947 he moved to Florida and became pathologist and director of the clinical laboratory for the Halifax District Hospital in Daytona Beach.

Prominent as a Masonic leader, Dr. Lippincott was a Shriner and a member of the Scottish Rite and York Rite bodies. From 1926 to 1942 he served as secretary-treasurer of the Vicksburg Masonic Temple, was a past president of that body and also was a past grand master of the Grand Council of Mississippi. A member of the Elks Lodge, he was a past exalted ruler of that body in Vicksburg. In 1929-1930, he was governor of the seventeenth district of Rotary International. In Daytona Beach, he was active in the Rotary Club and St. Mary's Episcopal Church.

Dr. Lippincott was a member of the Volusia County Medical Association, the Florida Medical Association and the American Medical Association. He was also a diplomate of the American Board of Pathology, a fellow of the American College of Physicians, and a member of the American Society of Clinical Pathologists, the American Association of Pathologists and Bacteriologists, the American

Public Health Association, the New England Pathological Society, the Southern Medical Association, the Military Surgeons of the United States, the Association of Railway Surgeons, and the American Association for the Advancement of Science.

Surviving are the widow, Mrs. Grace Holcomb Lippincott; a daughter, Mrs. Emily Louise McKnight; and a son, Leon Stanley Lippincott, Jr.

Reuel Abram Ely

Dr. Reuel A. Ely of Tampa died Dec. 28, 1950 at the age of 68 after a prolonged illness. His death was attributed to cerebral hemorrhage.

Dr. Ely was the son of George and Carolyn Hoch Ely of Pennsylvania. He was a graduate of Jefferson Medical College of Philadelphia in the class of 1910 and served his internship at the Reading General Hospital. He was a member of the Phi Rho Sigma medical fraternity. Before coming to Tampa in 1912, he was a member for one year of the faculty of the Atlanta College of Physicians and Surgeons, now Emory University.

Dr. Ely was a general practitioner and was a member of the staff of the Tampa Municipal Hospital, where he served as Chief of Surgery for one year near the close of the first World War. Locally, he was a member of St. Andrew's Episcopal Church and of the Masonic Lodge and the Egypt Temple Shrine.

A member and past president of the Hillsborough County Medical Society, Dr. Ely was also a member of the Florida Medical Association, the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Rhoda Weidman Ely; two daughters, Mrs. Eston Crowder, Jr., and Mrs. Lee Ward; and one son, Richard Ely, all of Tampa.

Lester Wallace Horne

Dr. Lester W. Horne of St. Petersburg died on Dec. 29, 1950 at the age of 70 years.

Born at Norway, Me., Dr. Horne was graduated from Tuft's College Medical School in Boston in 1904. He also held a degree from Rotunda Hospital, Dublin, Ireland.

Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance.^{1,2} Such states may involve any one of the organ systems or several at one time.^{1,3} The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vasoconstriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives.^{8,9,10.}

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In the early years of his professional career, Dr. Horne practiced medicine in Fairhaven and New Bedford, Mass. He was licensed in Florida in 1929 and established practice in St. Petersburg at that time. He engaged in general practice, but for some time prior to retirement a few years ago, he had specialized in proctology. He was on the staff of the Mound Park and St. Anthony's hospitals and after retirement served as librarian for both of these institutions. He continued to manifest keen interest in hospital and county society affairs.

Dr. Horne was a member of Oxford Lodge of Masons at Norway, Me. He was also a Royal Arch Mason and a Shriner.

A member of the Pinellas County Medical Society, Dr. Horne was also a life member of the Florida Medical Association and a member of the American Medical Association.



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BOOKS RECEIVED

RECENT ADVANCES IN NUTRITION, WITH PARTICULAR REFERENCE TO PROTEIN METABOLISM. By Paul R. Cannon, Ph.D., M.D. Price, \$2.00. Pp. 74. Lawrence, Kan.: University of Kansas Press, 1950.

Dr. Paul R. Cannon, author of this book just off the press Dec. 15, 1950, has for a decade been chairman of the Department of Pathology at the University of Chicago. His studies in nutrition have attracted wide attention. Here are presented conclusions based on extended experiments by Dr. Cannon and six collaborators, who by means of "the Rat-Repletion method" measured the protein values of certain foodstuffs. Though "caloric intake" and the importance of vitamins are not ignored, the chief topic is the vital role of the essential amino acids in maintenance of adequate protein reserves and in resistance to infection. The author supplies evidence that, for their proper use, these amino acids must be available at approximately the same time. He also touches upon the practical bearings of the new knowledge upon medical treatment during illness or after surgery. There are twenty-three graphs.



THE RHESUS DANGER, ITS MEDICAL, MORAL AND LEGAL ASPECTS. By R. N. C. McCurdy, M.B., Ch.B., D.P.H. London, William Heinemann Medical Books, Ltd., 1950.

This new, compact, 138 page contribution to the literature on the Rh factor is written to claim the attention of both professional and lay readers. The initial arresting statement is that in 1947 in England and Wales 18 out of every 1,000 children born died under the age of one year because of Rh incompatibility of their parents.

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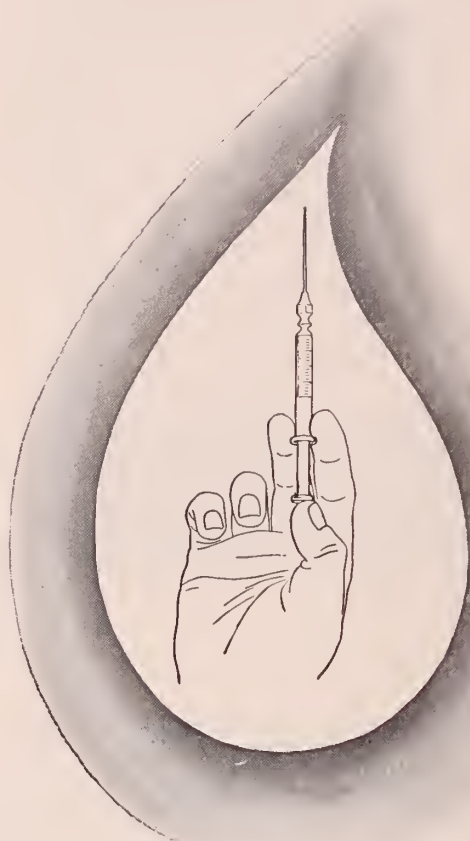
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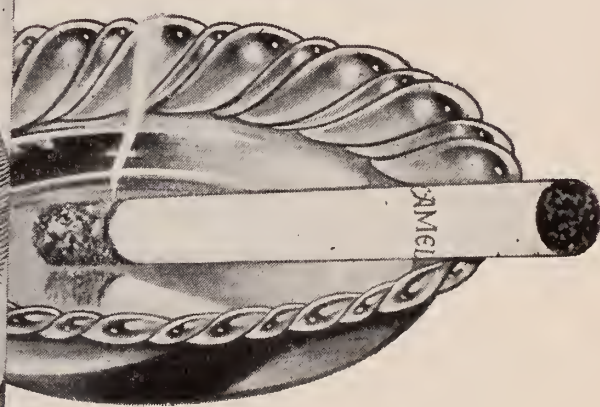
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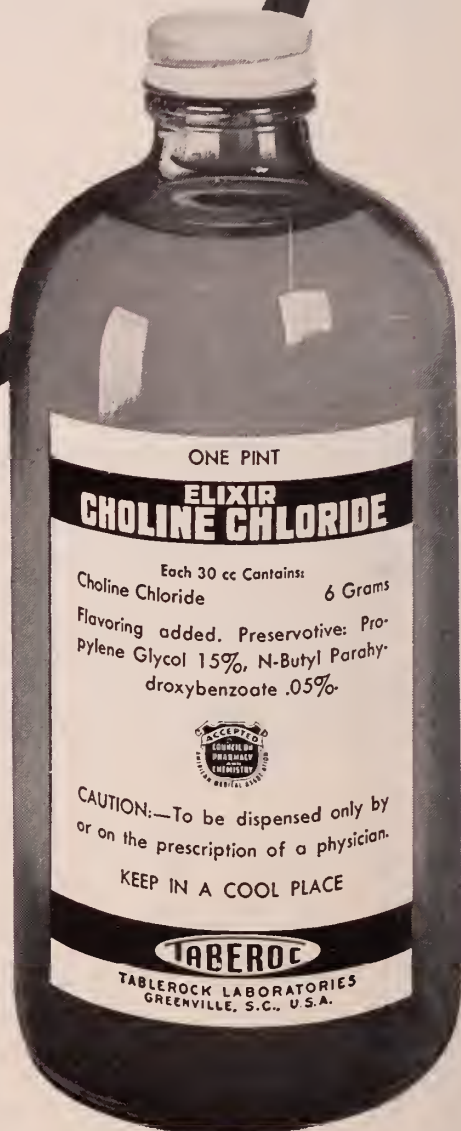
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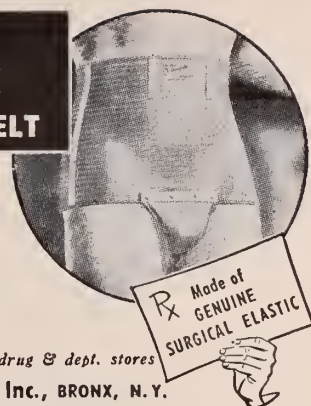
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PHOSPHORUS	0.94 Gm.	VITAMIN C	30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES	676

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Pensacola, 1951
B-Northeast	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	Orlando, 1951
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Bradenton-Sarasota, 1951
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	Vero Beach, 1951
Florida Specialty Societies			
Academy of General Practice	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	Hollywood, Apr. 22, '51
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	" "
Anesthesiologists, Soc. of	Ralph S. Sappenfield, Miami	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" Apr. 21-22, '51
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" Apr. 22, '51
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 2, '51
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	Ft. Lauderdale, Apr. 21, '51
Dental Society, State	D. Morrison, Sr., D.D.S., Gainesville	Larry Schulstad, D.D.S., Bradenton	Hollywood, Apr. 29-May 2, '51
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando
Hospital Service Corporation	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, June 24-26, '51
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
Public Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Apr. 5-6, '51
Woman's Auxiliary	Mrs. J. L. Anderson, Coral Gables	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 22-24, '51
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Houston, Texas, Dec 4-7, '51
Southern Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loran, Birmingham	Dallas, Texas, Nov. 5-8, '51
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	St. Petersburg, April 4-6, '51
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss., October, '51

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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	James M. Nixon, M.D. 825 Jenks Ave. Panama City	Harold E. Wager, M.D. Box 984 Panama City		22	16	A-1-52 Arthur J. Butt, Jr., M.D. Pensacola
	Escambia *Santa Rosa	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	7	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	6	4	
	Jackson *Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	11	
	Walton-Okaloosa	Arthur G. William, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	14	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	1	A-2-51 Taylor W. Griffin, M.D. Quincy
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	12	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	51	47	
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	6	
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	2	
	Taylor *Dixie-Lafayette	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	1	221
B	Alachua *Bradford, Gilchrist, Union	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	47	44	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Duval *Clay	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	244	160	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	28	22	
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClaue, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Claude M. Knight, M.D. 121 Madison St. Palatka	James W. Brantley, M.D. Grandin	2nd Tuesday 6:00 P.M.	10	9	
	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	14	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
	Brevard	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	19	18	
	Lake *Sumter	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	25	21	
	Orange *Osceola	Fred Mathers, M.D. 314 American Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	144	110	
	Seminole	Thomas F. McDaniel, M.D. 315 Magnolia Ave. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	13	12	
	Volusia *Flagler	Peter A. Drophomer, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	67	61	622
C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	159	120	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	13	
	Pasco-Hernando- Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	13	11	
	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	182	168	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	38	C-6-52 Leldon W. Martin, M.D. Sebring
	DeSoto-Hardee- Highlands- Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Edwin C. Northup, M.D. Box 98 Avon Park	2nd Tuesday 8:00 P.M.	25	22	
	Lee-Charlotte- Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	25	23	
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	85	65	
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	102	79	
	St. Lucie- Okeechobee- Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	17	12	
	Broward	M. Austin Lovcjoy, M.D. 401 Sweet Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	63	D-8-51 S. Marion Salley, M.D. Miami
	Dade	Jack O. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	558	308	
	Monroe	Ralph Herz, M.D. 420 Simonton St. Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	10	8	774

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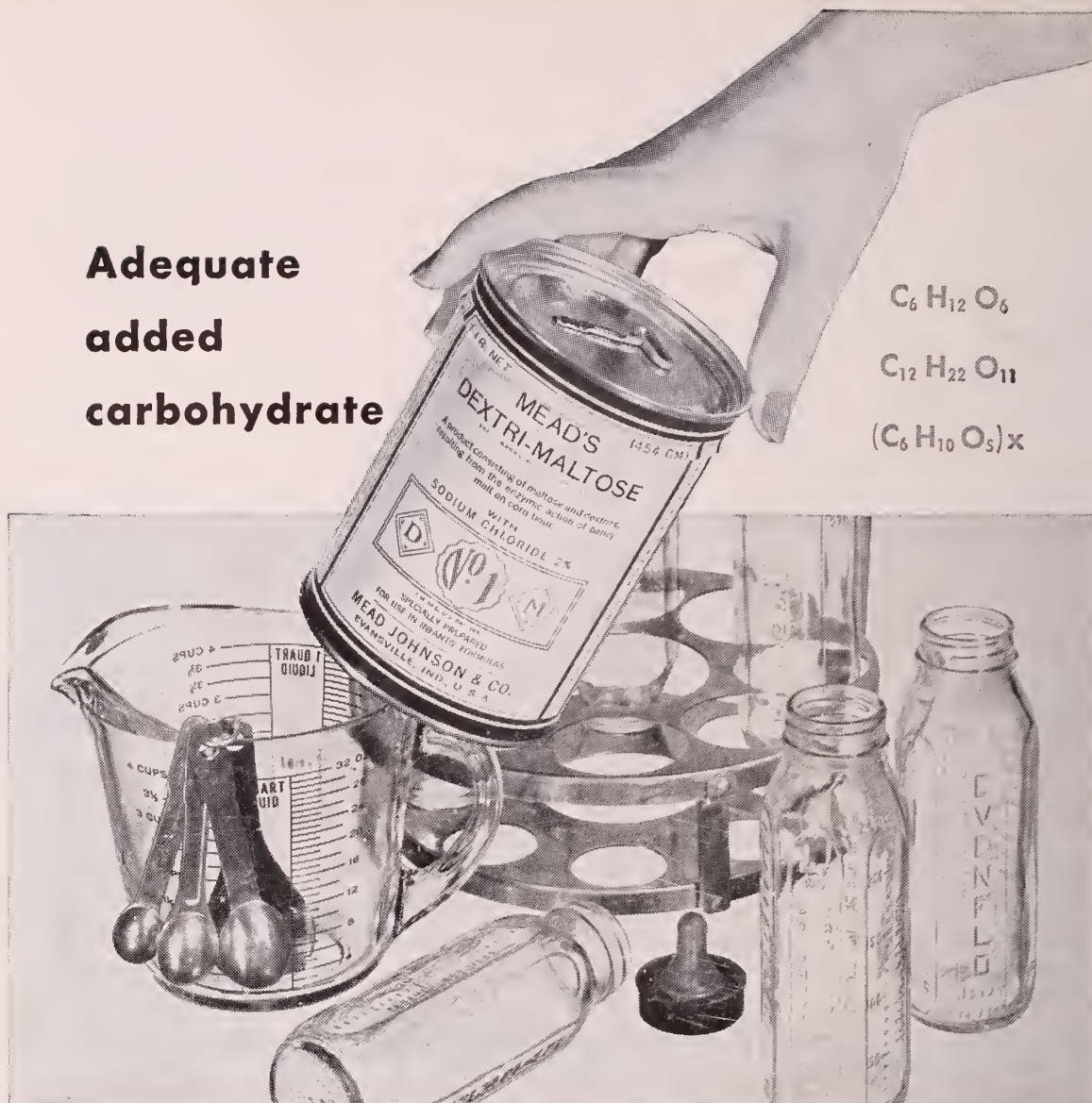
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

MAY, 1951

No. 11

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ACTH and Cortisone in Diseases of the Eye
Conrad Berens and Louis J. Girard



ACTH and Serum Sickness
Joseph G. Seltzer



May Anniversaries
An Editorial

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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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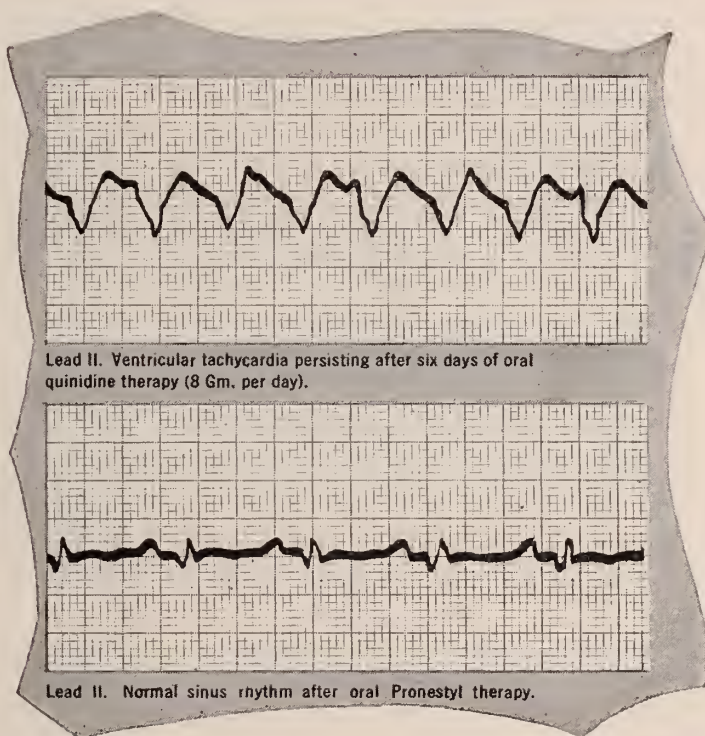
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1. Fauley, G. B., Freeman, S., Ivy, A. C., Atkinson, A. J., and Wigodsky, H. S.: *Arch. Int. Med.* 67:653, 1941.
2. Upham, R., and Chaikin, N. W.: *Rev. Gastroenterol.* 10:287, 1943.
3. Collins, E. N.: *J. A. M. A.* 127:890, 1945.

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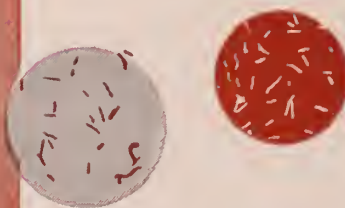
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*Linsell, W. D., and Fletcher, A. P.:
British M. J. 2:1190 (Nov. 25) 1950.

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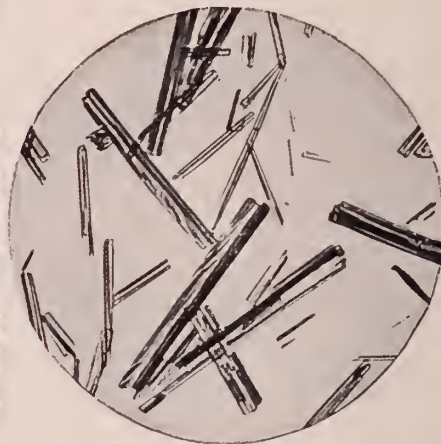
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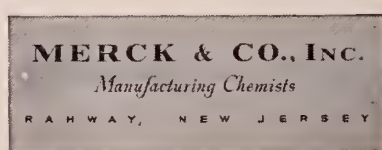
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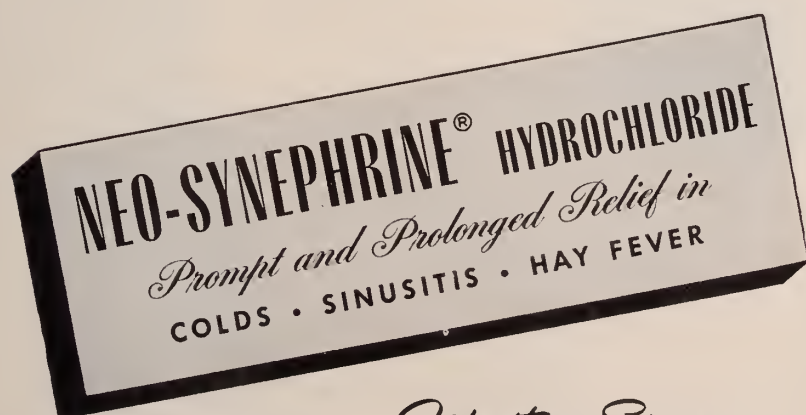
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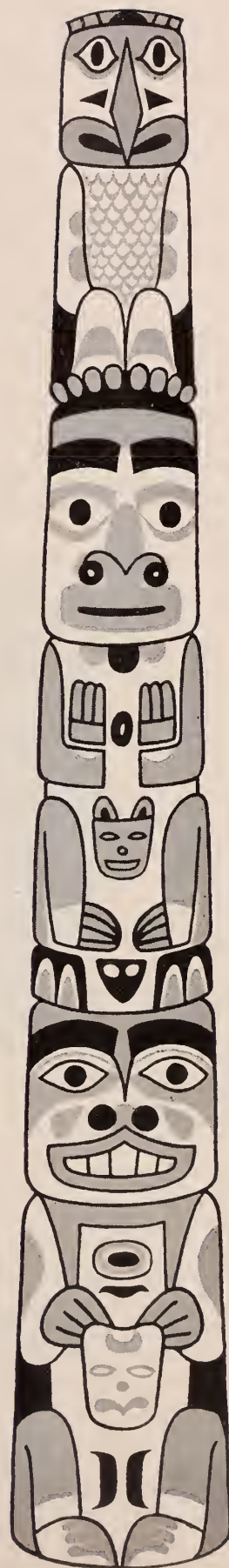


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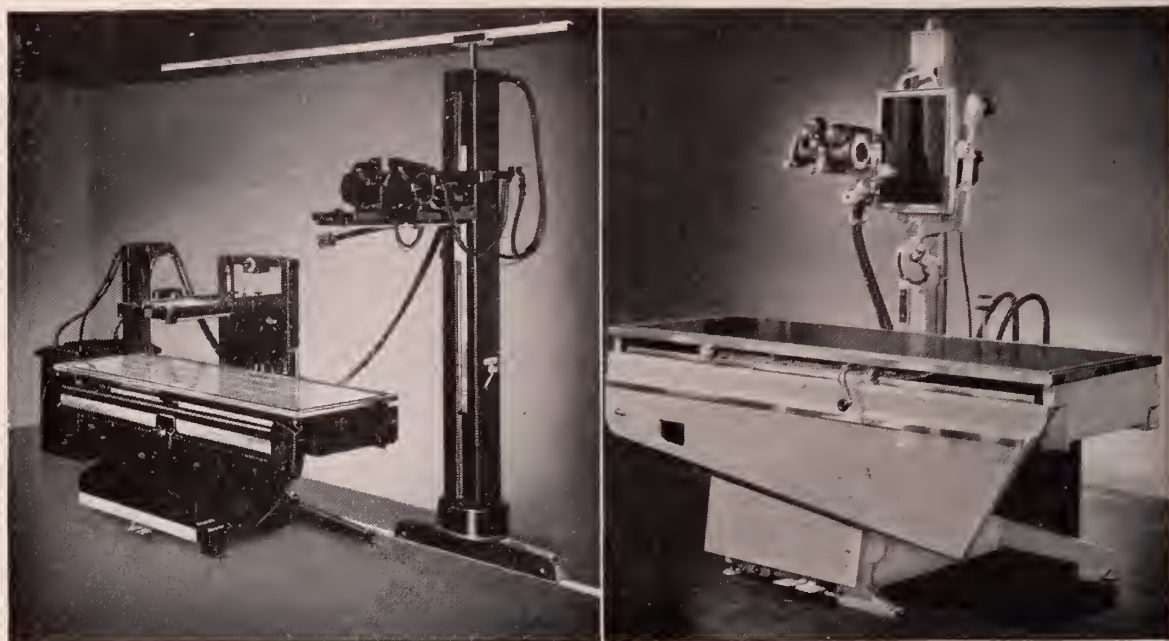
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Experiences with ACTH and Cortisone in Diseases of the Eye

CONRAD BERENS, M.D.

AND

LOUIS J. GIRARD, M.D.

NEW YORK

In attempting to evaluate the use of any therapeutic agents employed for as short a time as ACTH and cortisone have been, one must always keep in mind that the tendency in most diseases is for recovery to take place spontaneously. Furthermore, the more acute the process, the more likelihood there is that the disease will improve without treatment. In so far as ocular lesions are concerned, most investigators seem to stress that these preparations are especially valuable in treating acute conditions.

In evaluating any therapeutic measure it is almost impossible to select suitable cases as controls because of lack of exact information concerning the etiology of many inflammatory lesions, especially uveitis.¹ These preparations, however, have proved so valuable in certain conditions, for example rheumatoid arthritis and many acute inflammatory diseases of the eye, that it is desirable that we attempt to evaluate this form of therapy.

In this paper, we will present briefly some of the cases that have been treated by us and our hospital associates and make a comparison of our results with the reports made by others. We also will refer briefly to the indications, contraindications and some of the limitations and complications of this form of therapy so far as they are known from the general standpoint. A brief resume of the history of ACTH and cortisone will be outlined because many important metabolic and physiologic processes are affected and fundamental knowledge is required in order that dosage schedules may be regulated intelligently.

History

A little over a hundred years ago, Thomas Addison described the disease syndrome caused by the destruction or lack of function of the adrenal glands in human beings. It was only two decades ago that the fundamental derangement in electrolyte metabolism was clarified in reference to sodium and potassium. It was shown later that the removal of the adrenal glands in animals causes a syndrome similar to that observed in human beings. So far as the discovery of ACTH is concerned, it was only twenty-five years ago that Herbert Evans reported that pituitary extract could prevent atrophy of the adrenal glands which resulted from the removal of the pituitary glands in animals. The Armour Laboratories have been working for twelve years on ACTH in collaboration with J. B. Collip of McGill University. Little progress was made, however, until Sayers and Sayers developed a bioassay technic which allowed the more accurate determination of ACTH potency of pituitary gland fractions. Three years ago, Thorn first injected ACTH in human beings and determined by laboratory investigations that the hormone stimulated the adrenal glands.²⁻⁸

One of the first observations was that ACTH causes a decided drop in the number of circulating eosinophils in the peripheral blood. The brilliant researches of Hench and his colleagues⁷ in rheumatoid arthritis at the Mayo Clinic established the great benefit of ACTH in this disease.

Cortisone was first synthesized from bile acid in the Merck Laboratories in 1946. It is a crystalline hormonal substance of established chemical structure derived from the adrenal cortex which was isolated independently by Kendell of the Mayo Foundation, Wintersteiner and Pfiffner of Columbia University and Reichenstein in Switzerland. Since 1946 thousands of investigators in the United States and Canada have studied its action

Aided by a grant from The Ophthalmological Foundation, Inc.

From the Department of Research, New York Eye and Ear Infirmary with the cooperation of Drs. W. L. Hughes, B. F. Payne, R. E. Meek, M. Berlinc, J. H. Krug and P. Brikates and with the grateful acknowledgment of the personal communications submitted by Drs. A. B. Reese, J. H. Allen, H. G. Seheie and W. B. Clark.

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in man and animals. The effect of cortisone in some acute inflammatory diseases of the eye has been striking. Recently cortisone has been administered orally and seems to be as effective in the same dosage as by intramuscular injection. It has several advantages over ACTH in that it can be administered effectively topically, orally and subconjunctivally.

It seems evident from a study of the problem that the adrenal glands play an exceedingly broad role in determining whether an individual is sick or well, regardless of the illness or the cause of the illness. Since there seems to be no direct correlation between the metabolic processes altered by adrenal cortical stimulation and disease processes or their severity, the changes are probably produced by physiologic effects at the tissue cell level. Clinical improvement and physical changes may be concurrent on doses which produce no demonstrable metabolic shifts.

Before discussing cases treated by us, a brief review of cases reported in the literature seems desirable.

Review of the Indications for and Use of Cortisone and ACTH as Found in Recent Ophthalmic Literature and Unpublished Data

Increasing reports are appearing in the literature concerning the use of cortisone and ACTH in the treatment of diseases of the eye. During the First Clinical Conference on ACTH held in Chicago in 1949, 1 case of interstitial keratitis and 2 cases of acute iritis were reported in which there was benefit from the use of ACTH. In 1 case of relapsing iritis and 1 of episcleritis treated with ACTH by Mann and Markson⁸ results were beneficial. In 1950, Woods⁹ reported on the clinical and experimental observations of the effect of cortisone and ACTH in ocular diseases. Patients with uveitis of undetermined origin, with ocular tuberculosis, interstitial keratitis and some external inflammatory conditions of the eye were treated by intramuscular injections, by subconjunctival injections and by instillations into the conjunctival cul-de-sac. Immediate response, in most cases, was that of blocking inflammation, so that there was the appearance of improvement and striking lessening of symptoms such as pain and redness. According to Woods, the proper dosage for effective administration has yet to be worked out.

In January 1950, Gordon and McLean¹⁰ reported on the results of treatment of 6 patients with ACTH. In 2 cases of acute choroiditis and 1

case of chronic iridocyclitis the patient was benefited by the therapy. A patient with retinitis pigmentosa apparently obtained temporary benefit. In a case of severe corneal edema and a case of secondary glaucoma, no favorable response was exhibited. In the 6 patients there was a definite fall in circulating eosinophils, although 2 of the patients had eosinopenia on admission.

At the meeting of the residents of the Wilmer Institute of Ophthalmology in 1950, Woods reported benefit in cases of sympathetic ophthalmitis from the use of ACTH. Results in cases of retrolental fibroplasia treated by Woods have been somewhat uncertain. Olson and his associates¹¹ reported good results in inflammatory lesions of the eye from the use of ACTH. They were particularly impressed by the improvement of uveitis and keratitis.

In a recent paper Blake and his associates¹² made a study of the use of ACTH in glaucoma and reported their results in 8 cases. Whereas they were unable to show any demonstrable effect in the reduction of intraocular pressure in primary glaucoma, they did believe there was considerable benefit when ACTH was used in anterior uveal disease associated with increased intraocular pressure. They noted effective lowering of tension with the subsidence of the inflammatory process. The authors suggested that ACTH or some derivative may be useful in differentiating between primary and secondary glaucoma.

Steffensen and his associates¹³ reported recently on the experimental use of cortisone in inflammatory diseases of the eye. In their first report,¹¹ which covers the experimental use of adrenocorticotrophic hormone (ACTH) in the treatment of inflammatory diseases of the eye, they found that the beneficial results were equal to or exceeded those which are obtained from present day methods of therapy. They believed that these good results were achieved by adrenal response through stimulation from the injection of ACTH and that they surpassed the physiologic response to fever therapy. In this second communication, they reported the results of the treatment of 7 patients with cortisone. In 2 cases of keratitis with secondary anterior uveitis there was definite improvement with topical cortisone alone. Four patients with inflammatory disease of the eye received cortisone alone and all responded favorably. One of these patients later had a relapse and was successfully retreated with cortisone used topically.

They concluded that further investigations are necessary before any final conclusion can be drawn.

Remarkable improvement in 8 of 9 cases of acute recurrent iritis is reported by Koff and his associates¹⁴ from the subconjunctival injection of 0.2 to 0.4 cc. (25 mg. per cc.) of cortisone. Seven of the 9 patients failed to respond to former treatment which included typhoid vaccine injections intravenously, salicylates, atropine or local heat therapy. In 3 cases, chronic granulomatous uveitis was unaffected by systemic adrenocorticotrophic hormone and was likewise unaffected by cortisone injected subconjunctivally. Injections were made at 12 o'clock, 5 to 6 mm. from the limbus with a 23 gauge needle, and, when necessary, the procedure was repeated in forty-eight to seventy-two hours at different sites.

From the work of Arendshorst and Falls¹⁵ nonspecific desensitization seems to be raised by ACTH and cortisone (17-hydroxy-11-dehydrocorticosterone). These authors stated that when foreign therapy is successful in the treatment of diseases of the eye, there is also a release of cortisone from the adrenal cortex. The eosinopenia is a specific response to cortisone, and the duration of effective treatment seems to be associated with the duration of the eosinopenia. When there is no fall of the circulating eosinophils, there is no response to the injection of foreign protein.

Reese and Blodi¹⁶ in their monograph on retrolental fibroplasia reported treatment with ACTH in 14 cases, with administration of 20 to 25 mg. a day for fourteen days. Since then they have treated 5 additional patients. In 1 case, because of a too long follow-up interval, the patient became blind. In all other patients treated, the retrolental process was arrested or regressed. In no patient treated during the progressive stage did a partial or complete retrolental membrane develop. In 3 instances a second course of ACTH had to be instituted because of reactivation of the process after satisfactory regression. During the same period, in 8 infants with progressive retrolental fibroplasia who did not receive ACTH there developed the usual sequelae (3 with complete membranes, 3 with partial membranes, and 2 with white masses in the periphery).

These investigators stressed that ACTH is effective only in the acute phase of the disease and should be instituted when signs of definite and rapid progression, such as retinal edema or retinal detachment, appear. Dilation and tortu-

osity of the retinal vessels, with fundal hemorrhages, are not considered sufficient indications for instituting ACTH therapy in view of the high percentage of spontaneous regression at this stage of the disease.

Side effects of ACTH, all apparently temporary, were cessation of growth, tachycardia and glycosuria.

The rationale of the treatment, according to Reese and Blodi,¹⁶ is as follows:

1. There is good clinical and histologic evidence that retrolental fibroplasia is primarily a disease of the blood vessels, characterized by a dilatation of the existing blood channels and by their proliferation into the vitreous. It is known that induced hyperadrenalism inhibits the growth of mesenchymal cells, and that cortisone specifically inhibits the growth of capillaries. It seemed reasonable to expect, therefore, that ACTH might halt the vascular overgrowth which marks the beginning of retrolental fibroplasia.

2. In addition to this pharmacologic basis, there may also be a physiologic basis for the use of ACTH in the treatment of premature children with retrolental fibroplasia. There is ample evidence of hyperadrenalism during the last trimester of pregnancy, caused probably by the formation of ACTH and adrenal cortical steroids in the placenta. It is conceivable that these hormones may be necessary for the normal development of the fetus and that premature separation from the maternal hormonal environment has a deleterious effect.

3. We know that retrolental fibroplasia is a self-limiting disease and that it has never been known to develop in an infant older than three months. Since the child need be carried only over this critical period, the length of time during which hyperadrenalism must be induced is relatively short.

In 2 patients with retrolental fibroplasia seen by Scheie,¹⁷ the condition definitely reverted to normal following a course of cortisone therapy. In several other cases, progress of the disease seemed to stop.

Outline of Ophthalmologic Indications for Administering Cortisone and ACTH

Parenteral

1. Iritis, iridocyclitis and acute uveitis (especially acute cases)
2. Acute central retinitis, acute central choroiditis and chorioretinitis
3. Herpes zoster ophthalmicus
4. Optic neuritis
5. Sympathetic ophthalmitis.

6. Retrolental fibroplasia
7. Glaucoma secondary to uveitis

Cortisone-Topical or Subconjunctival

1. Keratitis
 - a. Nonspecific superficial keratitis
 - b. Interstitial keratitis
 - c. Deep keratitis (nonspecific)
 - d. Marginal ulcerative keratitis
 - e. Herpetic keratitis
 - f. Acne rosacea keratitis
 - g. Phlyctenular keratoconjunctivitis
2. Acute iritis and iridocyclitis
 - a. Chronic iritis (?)
3. Allergic conjunctivitis (atropine) and vernal catarrh
4. Scleritis, episcleritis (rheumatic and leprosy)
5. Disciform keratitis
6. Recurrent corneal abrasion
7. Granuloma of conjunctiva
8. Blepharitis
9. Phacoanaphylaxis
10. To delay healing of trephine and iridosclerectomy wounds
11. To aid in maintaining transparency of corneal grafts

Preparation and Administration of ACTH and Cortisone

It would appear that ACTH produces most beneficial results when 80 to 100 mg. a day is administered in divided doses, reducing the dosage gradually when a clinical response (improvement in the lesion or drop in circulating eosinophil count) is noted.

The drug should be continued for ten days to two weeks. This regimen may be repeated two to three weeks later if necessary. Some authors favor alternate courses of ACTH and cortisone of two weeks each, believing that this procedure at first stimulates, then rests the adrenal gland. This method is advantageous for more prolonged treatment.

We have received authoritative information that ACTH may be effective when administered orally.

The tendency to relapse after ACTH therapy can sometimes be prevented by the local use of cortisone for continued effect.

Cortisone has the advantage of administration either by injection, orally or locally in divided doses. Generally it is administered 300 mg. the first day, 200 mg. the second day and thereafter 100 mg. per day for seven to fourteen days. The same dosage is used by injection or orally. The preparation seems to bring about a reaction more promptly when administered orally than hypodermically (Cortone News, No. 4, Merck & Co.). Local cortisone is usually diluted with saline or zephiran 1:3000 in 1:4 dilution and is administered every hour. The dilution is necessary because of local irritation. Cortisone may be admin-

istered subconjunctivally in full strength (25 mg. per cc.) if precautions are taken not to inject beneath Tenon's capsule. Injections beneath Tenon's capsule may result in irritation and edema. The injection of 0.5 to 1.0 cc. is repeated twice weekly even though remains of previous injections can still be visualized beneath the conjunctiva.

The site of previous injection should be avoided, or necrosis of the conjunctiva may result.¹⁸

The fact that cortisone has not been released until recently and that it has been in limited supply has prevented a more extensive clinical and experimental trial of this preparation. Since ACTH has been released, the number of patients receiving this drug has increased markedly. The great cost of these preparations has made the board of directors of several hospitals anxious about the mounting cost of the department of pharmacology.

Preliminary Studies to Be Made Before the Administration of Cortisone or ACTH Systemically and Examinations at Intervals During Treatment

Since these drugs may cause a great change in the electrolyte balance, fluid retention and carbohydrate metabolism, it is advisable to know the metabolic and chemical status of the patient before systemic therapy is begun. The following tests are of value in pretreatment investigation and in following the metabolic status during treatment:

1. Temperature
2. Pulse
3. Blood pressure
4. Daily weight
5. Intake and output
6. Complete blood count
7. Peripheral or circulating eosinophil count (normal 200 cc.). The decrease in circulating eosinophils is usually 50 per cent after ACTH is begun and serves as a useful guide to the state of adrenal cortical activity.
8. Blood chlorides. Elevation will herald sodium chloride retention and concurrent fluid retention. It may be an indication for discontinuation of ACTH if restriction of intake is ineffectual.
9. Blood potassium. In view of substantial urinary excretion of potassium on adrenal cortical stimulation, the patient should be checked for potassium deficiency.

The local use of cortisone has not caused severe metabolic changes, and it may safely be used on an ambulatory basis.

Contraindications and Some Possible Adverse Effects of Cortisone and ACTH

1. Sodium retention and altered fluid balance as evidenced by edema, sudden gains in weight, polydipsia and oliguria.

2. Skin complications, acne and mild hypertrichosis (apparently indicating increased androgen activity). Striae atrophicae. Abnormal deposition of adipose tissue of the face (mooning or rounding facial contour), posterior part of the neck and buttocks. Hyperpigmentation and delayed wound healing. Mild purpuric skin lesions.
3. Changes in libido, potentia and menstruation (irregular menses, oligomenorrhea or amenorrhea).
4. Nervous system effects, such as euphoria, insomnia, changes in mood or psyche (depression), paresthesias and functional symptoms of psychoneurosis.
5. Weakness, fatigue, exhaustion and auricular fibrillation.
6. Impaired carbohydrate tolerance and glycosuria.
7. Alkalosis with lowered blood potassium levels.
8. Miscellaneous effect, namely, transient headaches, dizziness or lightheadedness, transient blurring of vision, thinning or excessive growth of hair. In the cases in which hormonal excess developed, the signs of excess disappeared when the drug was discontinued.
9. May increase intraocular pressure (cases 2, 19 and 20).
10. Allergy to the preparations (case 18).
11. The use of these preparations is contraindicated in patients with hypertension, diabetes, chronic nephritis, known psychotic and psychopathic personalities, Cushing's syndrome, congestive heart failure and hirsutism, and does not seem to benefit chronic primary glaucoma, retinitis centralis, cataract, exophthalmos, myopia, erythema multiforme, corneal edema (dystrophy), retinitis pigmentosa, juvenile Coats' disease, Cogan's syndrome (nonsyphilitic keratitis) and chronic uveitis.

Discussion of Certain Cases Treated with Cortisone and ACTH*

There seems to be little doubt that cortisone and ACTH act most effectively in inflammatory ocular lesions in which there is an allergic factor (bacterial, food, and others). These preparations seem to be especially efficacious in the destructive phase of an acute process when used for short periods, and when they are administered in this manner, there is little danger of serious systemic reaction.

Case 1: Uveitis Associated with Rheumatoid Arthritis.—Mr. M. H., aged 28, had badly swollen painful hands which had not been benefited by usual forms of treatment. There was a rapid beneficial effect upon the swelling of the hands, the pain in the hands and knees and the uveitis. Cortisone has had to be administered discontinuously in small doses for one year in order to control the general and ocular reactions.

Case 2: Cortisone Used in Myopia.—Miss E. M. R., aged 46, had myopia of 11 diopters and was given cortisone drops by instillation in a dilution of 1:4 in the right eye, along with subconjunctival injections of cortisone, by a confrere. Her left eye was similarly affected, but this eye was not treated. After one month of treatment, there developed attacks of blurred vision "black-out" in her right eye and two weeks later glaucoma with hemorrhages was diagnosed. The tension (Schiotz) was 43 mm. of mercury in the right eye and 17 mm. in the left eye. As no other factors seemed to be involved in the production of the unilateral glaucoma, we had to give serious consideration to the possibility that the glaucoma in her case had been induced by the cortisone. In another case, cyclitis following cataract extraction, the systemic use of ACTH or cortisone was advised against by the consulting ophthalmologist because of the fear of increasing tension. He advised the use of cortisone locally, however, but the tension rose while it was being administered, and its use was discontinued.

Case 3: Chronic Iridocyclitis, Both Eyes, with Secondary Glaucoma.—Madame L. B., aged 42, had been treated for three years for ocular tuberculosis, and there was revealed upon our examination severe chronic streptococcus infection, especially in the throat and tonsils. She was apparently considerably benefited by removal of her tonsils. When the ocular disease did not subside completely, cortisone (1:4 in saline) was used locally every hour during the day and every two hours during the night. During the use of cortisone, the eyes were somewhat irritated, and the tension rose in spite of the use of pilocarpine, eserine and dionin. The local use of the drug was discontinued after five days. Because of the seriousness of the situation, vision having been reduced to 10/200 in each eye, systemic cortisone was administered, 200 mg. the first day and 100 mg. a day for one week, but after eight days the appearance of edema of the legs and face and gain in weight necessitated the discontinuation of the drug. No apparent benefit was observed in the patient from the local or systemic use of cortisone so far as the ocular condition was concerned.

Case 4: Serous Separation of the Retina, Right Eye, and Old Retinal Detachment, Left Eye, with Complete Loss of Vision.—Mr. G., aged 32, experienced retinal separation in the right eye which seemed to be a serous detachment and involved the lower third of the retina. This subsided rapidly with bed rest, subconjunctival injections of saline and the use of antihistamine preparations. The patient was allowed to walk about. After a month a new detachment occurred nasally. Since the first detachment had been associated with a mild asthmatic attack and some skin eruptions on the face and had subsided under antiallergic treatment, the use of cortisone subconjunctivally was instituted. The first two injections were associated with a reduction in the elevation of the retina from 15 D. to 3 D., but after this the elevation returned to 8 D. The retina was still separated nasally after two months' rest in bed and ten subconjunctival injections of cortisone. Our conclusion is that benefit (if any) in this case was only temporary.

Case 5: Chronic Allergic Keratoconjunctivitis Associated with Staphylococcus Aureus Conjunctivitis and Allergic Dermatitis.—Mr. T. C., aged 50, has been followed the longest under ACTH and cortisone therapy administered by Dr. Thygeson. For four or five years he has had a superficial keratitis which was highly vascu-

*Our own cases and those of some of our associates at the New York Eye and Ear Infirmary.

larized and has reduced his vision markedly. A definitely allergic skin eruption associated with the ocular lesion, involving the face especially, has not been benefited by antibiotic treatment (large doses of penicillin and other antibiotics) nor by cutting the cervical sympathetic nerve in the hope of breaking up the reaction which was considered to be allergic. The ocular lesion has not responded to application of radium to the cornea. Every possible means of eliminating a staphylococcus infection of the conjunctiva and the nose and throat had been tried. The patient was unusually sensitive to intradermal staphylococcal test injections. Following the systemic administration of cortisone, the conjunctival eosinophilia immediately disappeared, and the staphylococci were reduced in number. It was necessary to use bacitracin to eliminate them completely. The plan was to continue the lowest dose of ACTH or cortisone that would keep him symptom-free.

Treatment with cortisone was started Jan. 3, 1950; the total dosage was 100 mg. daily, divided into four doses of 25 mg. each intramuscularly at six hour intervals. Cortisone was reduced to 50 mg. per day, and within forty-eight hours there was a return of both dermal and ocular symptoms. ACTH was then administered, 40 mg. daily given in doses of 10 mg. each intramuscularly at six hour intervals. Response was slower than to cortisone. Within seventy-two hours improvement in the condition of both the skin and the eye was noted.

Case 6: Glaucoma and Nuclear Cataracts in Both Eyes.—Mrs. K. S. P., aged 70. In spite of our inability to reduce the sedimentation rate and Schilling index to normal, bilateral iridocorneosclerectomies were performed successfully, which controlled the tension well for one year. The tension in the left eye was uncontrolled with DFP, neosynephrine and pilocarpine following a cataract extraction. The use of ACTH generally was considered at one time because of the belief that it might be of some benefit against the underlying general infection, but the consultant advised against this and suggested the use of cortisone locally. Cortisone was used in 1:4 dilution, 1 drop in the left eye every hour. This therapy was discontinued after ten days because tension rose (fig. 1) and the eye which was allergic to several drugs applied locally was more irritated.

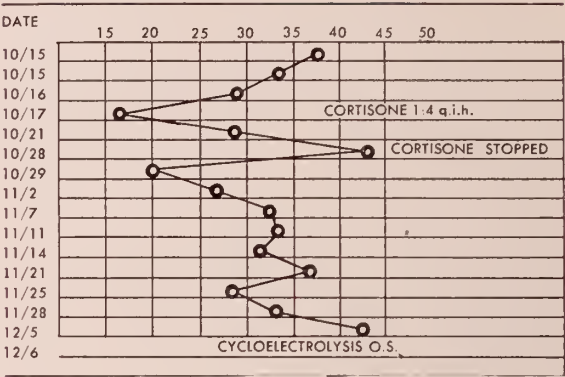


Fig. 1.—The topical application of cortisone in 1:4 dilution in zephiran in a patient with chronic iridocyclitis and secondary glaucoma following a cataract extraction was accompanied by a consistent rise in tension during the administration of cortisone for eight days. Tension fell rapidly after the cortisone was discontinued.

Case 7: Retrobulbar Neuritis in Both Eyes.—Mr. T. C., aged 28. A large central scotoma developed suddenly in the left eye apparently unrelated to anything that could be determined by his ophthalmologist. He was given the usual treatment including high doses of vitamins, non-specific therapy and antibiotics, but the central vision continued to deteriorate. When he was seen by us, the right eye was unaffected although he complained somewhat of blurring of vision of this eye. We could make out no central scotoma in the right eye (fig. 2A). While he was under observation to try to determine some possible cause, there developed suddenly a scotoma in the right eye, and the vision rapidly decreased to 10/200 (fig. 2B). The patient was hospitalized, and because toxic streptococci¹⁹⁻²¹ were found in his tonsils, a tonsillectomy was performed. Four days later the field was enlarged, and vision be-

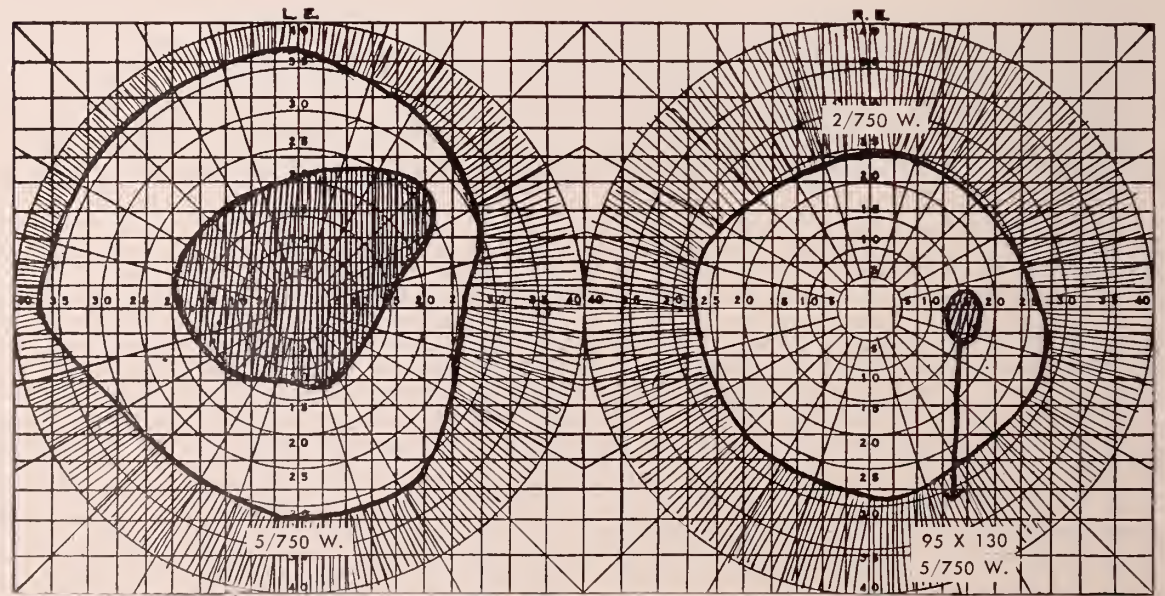


Fig. 2A.—Fields of a patient with acute retrobulbar neuritis. Field of the right eye with 1 mm. test object at 750 mm. taken with 7.5 foot-candles of artificial daylight illumination. Appearance normal with no central scotoma.

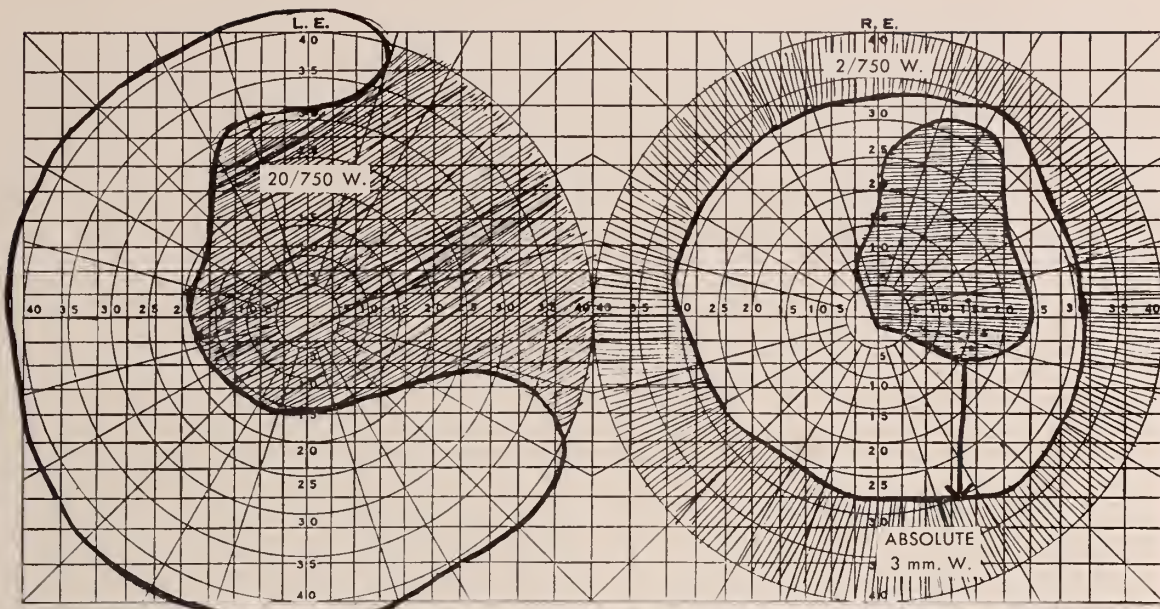


Fig 2B.—Fields of a patient with acute retrobulbar neuritis. Sudden appearance of central scotoma in the right eye. Removal of tonsils seemed to halt the progress in this eye. ACTH administered for ten days was not beneficial.

came somewhat improved and seemed to be stabilized (fig. 2C). At this time the use of ACTH was begun after consultation with Dr. Dunnington, but after ten days' trial of the preparation no apparent improvement was noted in the fields or vision. Slow improvement has followed sphenoidectomy and ethmoidectomy.

Case 8: Optic Neuritis Associated with Thrombosis of the Central Vein.—R. B., a boy aged 8. All treatment of the usual nature (nonspecific therapy and antibiotics) seemed to be of no benefit, and he was given two weeks' treatment with ACTH. Even under the application of ACTH the hemorrhages and edema of the nerve in the right eye increased. When last seen the patient showed no improvement, so far as we could determine, from any of the treatment and certainly not from the ACTH.

Case 9: Scleritis, Left Eye.—Mrs. C. L., aged 62. The topical application of cortisone 1:4 every hour resulted in greatly diminished congestion and irritation in twenty-four hours, and the nodule disappeared in three days (fig. 3). The patient is rheumatic and has sphenopalatine ganglion pain on the left side.

Case 10: Recurrent Iridocyclitis with Secondary Glaucoma, Right Eye.—Mr. J. D., aged 48, when first seen by us was having an acute recurrence of iridocyclitis in the right eye with numerous posterior synechiae, mutton-fat keratic precipitates and elevated tension. Mydriatics and hot compresses were prescribed; three days later there was only mild congestion, and the pupil was fully dilated. The keratic precipitates were unchanged. Cortisone 1:4 was given locally every four hours. One week later the eye

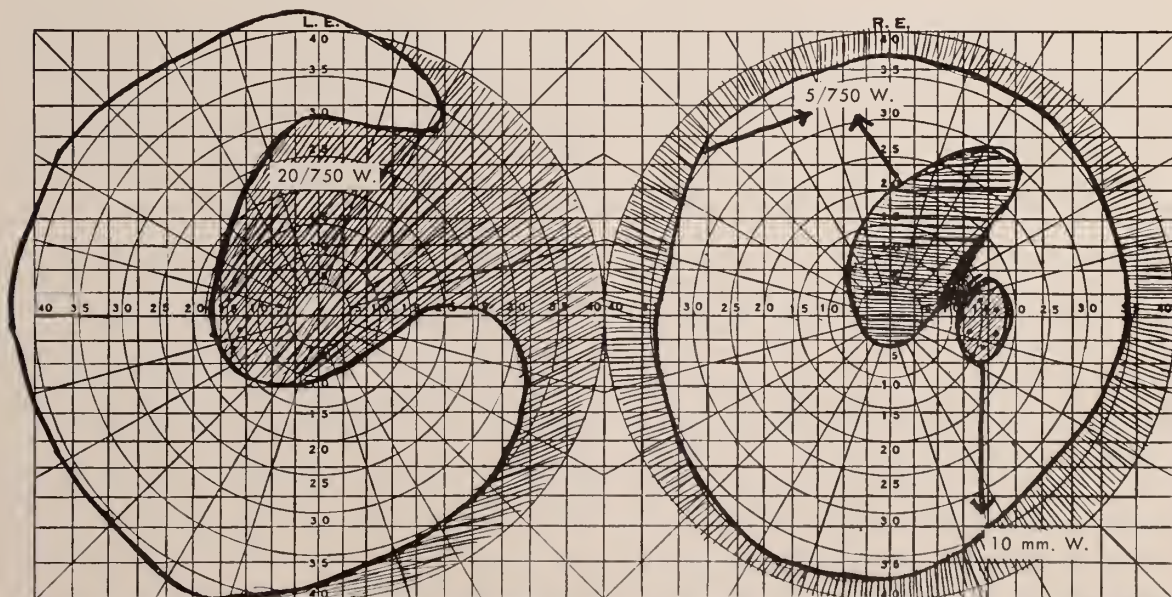


Fig 2C.—Fields of a patient with acute retrobulbar neuritis. Fields after opening sphenoids and ethmoids showed slight improvement.

was white. The keratitic precipitates had become smaller and discrete, and no flare or cells were observed in the aqueous. In this case of acute recurrent iridocyclitis there apparently was benefit from topical application of cortisone, although the usual treatment had begun to be beneficial when cortisone was first administered.

Case 11: Fuch's Epithelial Dystrophy, Both Eyes.—C. B., aged 52. Corneal transplantation was performed on the right eye when the center of the cornea appeared to be breaking down. There was uneventful recovery with good healing of the graft. Within three weeks after operation, however, the graft became hazy, and vision in the right eye was reduced to 20/200. The patient was given cortisone 1:4 locally for one week and then subconjunctivally (0.5 cc. of a 1:2 dilution) twice a week for two weeks without objective improvement.



Fig. 3.—Mrs. C. L., 62 years of age; scleritis in the left eye. The topical application of cortisone 1:4 every hour afforded almost immediate relief of symptoms in twenty-four hours, and the nodule disappeared in three days. The patient is rheumatic and has sphenopalatine ganglion pain on the left side.

Case 12: Acute Plastic Iritis, Right Eye.—J. W., aged 26, was given a complete course of treatment for iritis including mydriatics, salicylates, antibiotics, intravenous typhoid (six series) without improvement. ACTH was administered generally beginning with 25 mg. four times a day. The eye became white in seventy-two hours, and ACTH was gradually reduced. In this case there was a dramatic beneficial response to ACTH therapy when classic treatment had failed.

Case 13: Alkali Burn, Right Eye.—J. L., aged 49. Vision was reduced to hand movements. Classical treatment was administered resulting in slow healing with frequent breaking down of epithelium. Secondary glaucoma developed one month after injury, and the anterior chamber of the right eye was aspirated with complete removal of the epithelium. Again, the patient was given the usual treatment, but one month later a central stain of the cornea with surrounding edema of epithelium was still present. Cortisone 1:4 was administered locally every hour, and there was rapid and complete healing. When last seen the cornea was completely healed with scarring, and vision in the right eye was 20/200.

Case 14: Perforating Wound of Cornea and Prolapse of Iris, Left Eye; Possible Sympathetic Ophthalmitis.—T. M., aged 8, had a previous history of infantile allergies with urticaria from food or possibly on a contact basis. A perforating wound of the cornea with prolapse of the iris occurred on Oct. 7, 1950, followed by photophobia, congestion and profuse lacrimation. Symptoms continued for two months. Cortisone acetate diluted 1:4 in zephiran 1:3000 was instilled in the left eye, 1 drop hourly. In four days, photophobia, lacrimation and congestion markedly improved, and after seven days the patient had only slight photophobia; the eye was white and comfortable except upon direct exposure to strong light. Cortisone was of definite benefit in lessening symptoms and signs of inflammation and irritation.

Case 15: Chronic Uveitis with Secondary Glaucoma, Both Eyes.—E. T., aged 49, had a positive Wasserman reaction three years prior to admission. There was a history of several previous admissions for uveitis treated by intravenous typhoid. On this admission, tension was 40 mm. of mercury (Schiotz) in both eyes. Tension remained uncontrolled in spite of repeated paracentesis, typhoid vaccine intravenously and finally DFP and other miotics. Bilateral cycloelectrolysis was performed, which brought the tension to 15 mm. in the right eye and 36 mm. in the left eye. A spontaneous hyphema developed in the right eye, however, and formed an organized clot which had to be removed.

In view of uncontrolled tension in the left eye, ACTH therapy was begun, 10 mg. four times a day. After three days tension in the left eye was reduced to 23 mm., but then began to rise again. ACTH was increased to 25 mg. four times a day, but tension rose in both eyes to 46 mm. in the right eye and 36 mm. in the left eye. After three weeks of ACTH therapy, the drug was discontinued, and the right eye was enucleated because of pain, faulty light projection and signs of degeneration. Tension in the left eye returned to normal and has remained so without any medication.

It was concluded that ACTH had been of no benefit in this case.

Case 16: Chronic Uveitis with Secondary Glaucoma, Left Eye.—E. W., aged 43, presented a lengthy history of repeated attacks of iritis and adherent leucoma in both eyes. Vision in both eyes was reduced to counting fingers. Tension fluctuated between 35 and 40 mm. of mercury (Schiotz) in the left eye. ACTH, 10 mg. four times a day, was first administered, and the dosage was increased gradually to 25 mg. four times a day over a period of ten days. Tension was unaffected by the treatment, and the drug was discontinued after two weeks. Cycloelectrolysis was performed on the left eye, and the patient was discharged one week later with tension 23 mm. in both eyes. No benefit could be attributed to ACTH therapy.

Case 17: Acute Plastic Iritis, Left Eye.—S. G., aged 50, was admitted to the New York Eye and Ear Infirmary for cortisone therapy. No other drugs were used. Cortisone 1:4 in saline was instilled locally every hour in the left eye. The response was rapid and dramatic. The patient was discharged after a week with no flare, no cells and no keratitic precipitates visible in the anterior chamber. Cortisone 1:4 drops every four hours was continued on an ambulatory basis, but two weeks later there developed an acute recurrence in the left eye. Cortisone 1:4 every hour and atropine 3 per cent three times a day were prescribed, and the response was again rapid and on this occasion appeared to be permanent.

Case 18: Marginal Corneal Ulcer; Allergic Dermatitis of the Eyelid, Left Eye.—C. D. V., aged 56, had a history of corneal ulcer in the left eye, which had been treated with penicillin ointment. A severe allergic reaction had developed. Culture of the conjunctiva of the left eye showed *Staphylococcus aureus* nontoxic, nonhemolytic.

Cortisone 1:4 in saline was administered every hour in the left eye with improvement of both lesions for the first forty-eight hours, followed by an acute allergic edema of the eyelids. Cortisone was discontinued, and antihistaminics (pyribenzamine 100 mg. every four hours, and antistineprinine drops three times a day in the left eye) were instituted. The response was rapid improvement, and the patient was discharged five days later.

The patient returned in one week with a marginal corneal ulcer in the right eye. Cortisone 1:4 was administered hourly in this eye. In twenty-four hours a severe allergic edema developed in the right eye. Cortisone every hour was continued accompanied by antihistaminics. The ulcer healed rapidly, and the allergic reaction subsided gradually over a period of three weeks.

Patch tests showed reaction to penicillin, but not to cortisone in spite of the repeated allergic dermatitis which resulted from its use.

Case 19: Chronic Uveitis; Chronic Secondary Glaucoma, Both Eyes.—Mrs. G. H., aged 47, had a long history of treatment for glaucoma, with multiple operations for glaucoma without controlling tension. She had had seven operations on the left eye and two on the right eye. ACTH therapy (10 mg. four times a day) was started on Sept. 10, 1950. Tension at this time was in the right eye 41 mm. of mercury and in the left eye 15 mm. (Schiotz). ACTH was increased to 15 mg. four times a day on September 21, and to 25 mg. four times a day on September 26. Tension increased in the left eye to 41 mm. and ACTH was gradually diminished without a decrease in tension. ACTH was finally discontinued on October 18. The conclusion was that ACTH had been of no benefit.

Case 20: Aphakia, Anterior Uveitis and Secondary Glaucoma, Right Eye.—Mr. F. G., aged 43, had a history of cataract extraction and iridocapsulotomy in June 1950. Glaucoma developed three days before admission, and the classic treatment for secondary glaucoma was given including antibiotics, mydriatics and typhoid vaccine intravenously. Tension was brought to normal within a few days. On Sept. 18, 1950, however, there developed an acute attack of uveitis without increasing tension. Treatment was started with cortisone, 3 per cent topical, every hour. Tension began to rise and on September 26 was 42 mm. of mercury (Schiotz) in the right eye. The administration of ACTH (10 mg. four times a day) was begun, followed by aspiration of the aqueous the next day. Tension was reduced to 29 mm. in the right eye; ACTH was increased to 15 mg. four times a day, and on September 30 ACTH was increased to 30 mg. four times a day. Tension increased to 45 mm. in the right eye, and on October 3 the administration of ACTH and cortisone was discontinued. The patient was given 20 million triple typhoid vaccine intravenously, and in twenty-four hours the tension decreased to a normal 21 mm. On October 13, ear, nose and throat consultation suggested irrigation of both antrums, and 2+ pus was found. The eye became quiet shortly afterwards, and the patient was discharged on October 17.

The anterior uveitis and secondary glaucoma were not benefited by cortisone or ACTH. Apparently improvement was obtained by the administration of typhoid vaccine and irrigation of the antrums.

Because of the limitation of space, the other cases seen by our confreres at the New York Eye and Ear Infirmary and by us and those reported to us in personal communications are tabulated in table 1.

To facilitate the comparison of methods of treatment and results, the literature of cortisone and ACTH therapy has been tabulated (table 2).

Summary

It is too early to draw final conclusions concerning the value of cortisone and ACTH in diseases of the eye, but we have presented a brief review of our experience with these preparations and some published and unpublished data from the experience of others. We and our associates at the New York Eye and Ear Infirmary have treated 96 cases and consider that in 65 there was definite benefit and in 1 case probable benefit, but in 30 cases no improvement was noted. From our own experiences and those of other ophthalmologists, we believe the systemic administration of ACTH and cortisone is indicated in iritis, iridocyclitis and uveitis (especially acute cases); acute central retinitis, acute central choroiditis and chorioretinitis; herpes zoster ophthalmicus; optic neuritis, including retrobulbar neuritis; sympathetic ophthalmitis; retrolental fibroplasia, and glaucoma secondary to uveitis. The topical or subconjunctival administration of cortisone is indicated in superficial keratitis (nonspecific), interstitial keratitis, deep keratitis (nonspecific), marginal ulcerative keratitis, herpetic keratitis, acne rosacea keratitis, phlyctenular keratoconjunctivitis; acute iritis and iridocyclitis (chronic iritis?); allergic conjunctivitis (atropine) and vernal catarrh; scleritis, episcleritis (rheumatic and leprosy); disciform keratitis; recurrent corneal abrasion; granuloma of the conjunctiva; blepharitis; and phacoanaphylaxis.

The use of these preparations is contraindicated in patients with hypertension, diabetes, chronic nephritis, known psychoses and psychopathic personalities, Cushing's syndrome, congestive heart failure, and hirsutism. Cortisone and ACTH do not seem to benefit chronic primary glaucoma, retinitis centralis, cataract or exophthalmos.

The dosage and methods of application of these preparations are still in an experimental stage so far as the diseases of the eye are concerned, but we believe the following general doses are applicable: ACTH appears to have the most beneficial results when administered in divided doses of 80 to 100 mg. a day, with reduction of the dosage gradually when a clinical response (improvement in the lesion or drop in the circulating eosinophil count) is noted. For prolonged effect it is desirable to alternate the use of cortisone and ACTH, using each preparation for from ten days to two weeks, thus alternately stimulating and resting the adrenal gland. Systemic use of ACTH may be alternated with the use of cortisone locally.

Table 1.—Cases Treated with Cortisone and ACTH†

No. of Cases	Diagnosis	Therapy	Results	Submitted by
1	Blepharitis	Cortisone—topical	Improvement	Hughes
1	Cataract	Cortisone—topical	Improvement (?)	Payne
5	Episcleritis	Cortisone—topical	Improvement (4) No improvement (1)	Payne, Brikates, Allen Krug
1	Episcleritis	Cortisone—systemic	No improvement	
3	Leprosy scleritis	Cortisone—topical	Improvement (3)	Allen
1	Scleritis	Cortisone—topical	Improvement	Berens
3	Acute plastic iritis	Cortisone—topical	Improvement (3)	Hughes, Krug
1	Acute plastic iritis	ACTH	Improvement	Girard
1	Uveitis, rheumatoid arthritis	Cortisone and ACTH	Improvement	Berens
2	Anterior uveitis	Cortisone—systemic	Improvement (2)	Berliner
1	Anterior uveitis, secondary glaucoma	Cortisone and ACTH	Discontinued*	Girard
2	Anterior uveitis, secondary glaucoma	Cortisone—topical	No improvement (2)	Hughes
1	Chronic uveitis	ACTH	Discontinued*	
1	Chronic uveitis, secondary glaucoma	ACTH	No improvement	Girard
1	Nongranulomatous uveitis	Cortisone—systemic	Discontinued*	Clark
1	Granulomatous uveitis	Cortisone—systemic	Discontinued*	Clark
2	Chronic iridocyclitis, secondary glaucoma	ACTH	Discontinued*	Girard
1	Chronic iridocyclitis, secondary glaucoma	Cortisone—topical	Discontinued*	Girard
3	Iridocyclitis	Cortisone—topical	Improvement (3)	Payne, Brikates
1	Recurrent iridocyclitis, secondary glaucoma	Cortisone—topical	Improvement	Berens
1	Chorioretinitis (acute)	ACTH	No improvement	
1	Paracentral chorioretinitis	Cortisone—topical	Improvement	Krug
1	Choroiditis (neuropathic)	Cortisone—topical and systemic	Improvement	Meek
1	Choroiditis (central)	Cortisone—systemic	Improvement	Meek
3	Corneal ulcers	Cortisone—topical	Improvement (3)	Hughes, Berens
1	Marginal ulcer (allergic)	Cortisone—topical	Discontinued*	Girard
2	Dendritic ulcer and iritis	Cortisone and atropine	Improvement (1) No improvement (1)	Krug Krug
1	Recurrent corneal abrasion	Cortisone—topical	Improvement	Hughes
2	Chemical burn—cornea	Cortisone—topical	Improvement No improvement	Girard Payne
5	Retrolental fibroplasia	Cortisone—systemic	Improvement (5)	Scheie
19	Retrolental fibroplasia	ACTH	Improvement (18) Blind (1)	Reese Reese
2	Diabetic retinopathy	Cortisone—systemic	Subjective improvement (1) No improvement (1)	Berliner Berliner
2	Vernal conjunctivitis	Cortisone—topical	Improvement (2)	Allen
1	Myopia—progressive, secondary glaucoma	Cortisone—topical	Discontinued*	Berens
1	Granuloma (fornix)	Cortisone—topical	Improvement	Payne
1	Perforating wound of cornea, lens sensitivity, sympathetic ophthalmitis	Cortisone—topical	Improvement	Berens
1	Sympathetic ophthalmitis	ACTH	No improvement	Payne
1	Retinal detachment	Cortisone—systemic	No improvement	Berens
1	Chronic glaucoma	Cortisone—topical	No improvement	Berens
1	Fuch's epithelial dystrophy	Cortisone—topical and systemic	No improvement	Girard
1	Chronic staphylococcus keratoconjunctivitis	Cortisone—systemic	Improvement	Berens
1	Phlyctenular keratoconjunctivitis	Cortisone—topical	Improvement	Allen
1	Acute keratoconjunctivitis	Cortisone—topical	Improvement	Krug
1	Acne rosacea keratitis	Cortisone—topical	Improvement	Allen
1	Syphilitic interstitial keratitis	Cortisone—topical	Improvement	Allen
1	Interstitial keratitis (nonspecific)	Cortisone—topical	Improvement	Payne
1	Herpetic keratitis	Cortisone—systemic	Improvement	Berliner
1	Neuropathic keratitis	Cortisone—systemic	No improvement	Meek
2	Keratitis—deep-cholesterol type	Cortisone—topical	No improvement	Payne, Brikates
1	Disciform keratitis	Cortisone—topical	Improvement	Payne
1	Keratitis profunda	Cortisone—topical	Improvement	Krug
1	Endothelial epithelial dystrophy, bullous keratitis and aphakia	Cortisone—topical	No improvement	Hughes
1	Optic neuritis, thrombosis—central vein	ACTH	No improvement	Berens
1	Retrobulbar neuritis	ACTH	No improvement	Berens

†Our cases and personal communications from the following surgeons: Drs. A. B. Reese, H. G. Scheie, W. B. Clark, J. H. Allen, W. L. Hughes, B. F. Payne, R. E. Meek, M. Berliner, J. H. Krug, and P. Brikates.

*Therapy discontinued because of systemic effects.

Table 2. — Cases Treated with Cortisone and ACTH Reported in the Literature

No. of Cases	Diagnosis	Therapy	Results	Reported by
3	Sympathetic ophthalmitis	ACTH	Improvement (2)	Harvey
1	Sympathetic ophthalmitis	ACTH	Improvement	Woods
1	Sympathetic ophthalmitis	Cortisone-systemic	Improvement	Woods
1	Sympathetic ophthalmitis secondary glaucoma	ACTH	Improvement (tension and inflammation)	Blake
1	Iritis (nongranulomatous)	Cortisone and ACTH	Improvement	Woods
1	Iritis (nongranulomatous) secondary glaucoma	Cortisone-systemic	Improvement	Woods
9	Iritis chronic and recurrent	Cortisone	Improvement (8)	Koff
3	Acute plastic iritis	ACTH	Improvement (3)	Olson
1	Acute iritis, keratitic precipitates	ACTH	Improvement	Olson
4	Iritis-plastic and recurrent	Cortisone	Improvement (4)	Steffensen, Mann
2	Nongranulomatous iritis	ACTH	Improvement (2)	Harvey
1	Keratitis and anterior uveitis	ACTH	Temporary improvement	Olson
	Vernal conjunctivitis	Cortisone	Unknown	Henderson
2	Vernal catarrh	Cortisone-topical	Improvement	Woods, Scheie
	Vernal conjunctivitis	ACTH	Improvement	Harvey
2	Herpes zoster ophthalmicus	Cortisone-systemic	Improvement	Harvey
1	Retinitis centralis	Cortisone	Improvement	Steffensen
	Exophthalmos- hyperthyroidism	Cortisone	No improvement	Thorn
8	Myasthenia gravis	ACTH	Variable	Torda-Wolfe
	Advanced cataract	ACTH	No improvement	McLean
1	Pemphigus	Cortisone	Temporary improvement	Woods
	Alkali burn-cornea	Cortisone	Some improvement	Woods
1	Herpes simplex	Cortisone	Improvement	Scheie
	Erythema multiforme	Cortisone	No improvement	Scheie
1	Superficial discrete keratitis with diabetes and coronary disease	ACTH	Improvement	Mazar
	Arthritic lesions	Cortisone	Improvement	Henderson
2	Retrolental fibroplasia (table 1)	ACTH	No improvement	Woods
4	Primary glaucoma	ACTH	No improvement	Blake
1	Secondary glaucoma	ACTH	No improvement	Gordon
3	Secondary glaucoma	ACTH	Improvement (3)	Blake
1	Retinitis pigmentosa	ACTH	Temporary improvement	Gordon
1	Corneal edema, dystrophy	ACTH	No improvement	Gordon
1	Syphilitic interstitial keratitis	ACTH	No improvement	Woods
	Syphilitic interstitial keratitis	Cortisone-topical	Improvement	Barton
1	Congenital syphilitic interstitial keratitis	Cortisone and ACTH	Improvement	Steffensen
2	Acute choroiditis	ACTH	Improvement	Gordon
1	Tuberculous choroiditis, secondary glaucoma	Cortisone-systemic	Improvement	Woods
1	Juvenile Coats' disease	ACTH	Improvement	Woods
1	Cogan's syndrome (nonsyphilitic keratitis)	Cortisone-systemic	No improvement	Woods
1	Tuberculous uveitis, secondary glaucoma	Cortisone-systemic	Improvement	Woods
1	Tuberculous uveitis, secondary glaucoma	ACTH	Improvement	Woods
2	Anterior uveitis, herpes zoster	Cortisone	Improvement	Harvey
2	Tuberculous uveitis	ACTH	Improvement	Harvey
3	Tuberculous uveitis	Cortisone	Improvement	Harvey
1	Uveitis, secondary lens sensitivity	Cortisone	Improvement	Scheie
1	Uveitis, secondary glaucoma	ACTH	Improvement	Blake
1	Chronic uveitis	ACTH	Fair	Blake
1	Chronic iridocyclitis	ACTH	Improvement	Gordon, McLean
2	Acute choroiditis	ACTH	Improvement	Gordon, McLean
2	Keratitis, secondary anterior uveitis	ACTH and cortisone	Improvement	Steffensen
1	Tuberculous uveitis, secondary glaucoma	Cortisone-topical	Improvement	Woods
3	Uveitis	Cortisone-topical	Improvement (2)	Hollenhorst
3	Chronic uveitis	ACTH and cortisone	Improvement	Koff
1	Tuberculous sclerokeratitis	ACTH	Improvement	Woods
1	Sclerokeratitis	Cortisone-topical	Improvement	Woods
3	Granulomatous uveitis	ACTH and cortisone	No improvement	Koff
1	Disciform degeneration, macula	ACTH	Improvement	Woods

Cortisone may be injected or taken orally in 200 to 300 mg. doses the first day, 200 mg. the second day and 100 mg. doses thereafter for from seven to fourteen days. Locally, cortisone may be applied in a 1:4 dilution in 1:3000 zephiran, or as an ointment 25 mg. to the gram of ointment. Undiluted cortisone (25 mg. per cc.) may be injected subconjunctivally, but not under Tenon's capsule, every three or four days in a different location to avoid necrosis.

The mode of action of these preparations is still unknown, but the beneficial changes are probably produced at the tissue cell level, possibly by blocking the hypersensitivity of the cells to nonbacterial as well as bacterial substances.

Conclusion

The authors report 96 cases treated with ACTH and cortisone, in 66 of which varying degrees of benefit were apparently derived. No benefit was noted in the following conditions: chronic primary glaucoma, retinitis centralis, cataract, exophthalmos, myopia, erythema multiforme, corneal edema (dystrophy), retinitis pigmentosa, juvenile Coats' disease, Cogan's syndrome (nonsyphilitic keratitis) and chronic iridocyclitis and uveitis.

The therapeutic action probably takes place at the tissue cell level.

The conditions which respond best to treatment with these preparations are the acute inflammatory diseases and especially those which are usually self limited or in which allergy plays a role. They do not seem to benefit the chronic or degenerative lesions.

Because infection may be masked by cortisone and ACTH, the use of antibiotics, found to be effective against the organisms recovered from cultures, chemotherapy and immunotherapy, should not be neglected.

Until a large number of cases can be studied with adequate controls, it is advisable to maintain

a conservative attitude concerning the beneficial effects of these preparations on ocular inflammations.

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Parathion Poisoning in Florida Citrus Spray Operations

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The use of parathion for spraying citrus trees presents a new and important industrial health hazard to the Florida citrus industry. Although during the 1950 spray season over 1,000 tons of 15 per cent wettable parathion were used, only 50 cases of supposed parathion poisoning were reported to the Citrus Experiment Station, and these probably represented about half of the total number of cases which occurred.¹ In addition, approximately half of the reported cases were probably not caused by parathion absorption. During the latter part of the spray season two medical laboratories in the state were able to test blood as a means of diagnosing parathion poisoning. The test was based upon a determination of the amount of cholinesterase present in the plasma and red blood cells. Since cholinesterase is destroyed by parathion, this test provides an index to the amount of parathion absorption and may be used as a diagnostic aid in suspected poisoning.

It was reported elsewhere¹ that when cholinesterase determinations were made on blood from 13 men with more than thirty days' exposure to parathion in spray operations, no great decreases from the threshold value were found for either red blood cell or plasma cholinesterase levels, although the erythrocyte determination did average 10 per cent lower than that of the plasma. When the amount of parathion handled per day by each man was compared with changes in red blood cell cholinesterase levels, no correlation was found. A review of the reported poisoning cases, however, indicated that exposures of more than one week's duration were probably contributing to the incidence of parathion poisoning, and it was concluded that until more data were available, periods of exposure to parathion in citrus spray operations should be limited to one week with at least a week off between exposure periods. It was also con-

cluded that during citrus spray operations absorption through the skin was probably the most common route of entry for parathion into the body.

Originally it was considered that red blood cell cholinesterase would be a reasonably reliable indicator of other tissue cholinesterases. A drop in red blood cell cholinesterase to a point below 65 per cent of normal control was considered to be evidence of parathion absorption, but it was supposed that actual symptoms of parathion poisoning would not be evident prior to the time that blood cholinesterase levels dropped to about 25 per cent of normal control. Work by Grob, Garlick and Harvey² had indicated that following a reduction to about 25 per cent of control, a return to normal would be fairly rapid for plasma cholinesterase, but red blood cell cholinesterase would return at the rate of about 1 per cent per day, and therefore at least two months would be required for return to normality. Thus, it appeared that when illness occurred, cholinesterase levels would be dangerously depressed, but with the restoration of cholinesterase, recovery would be rapid and complete. Data collected in Florida in 1950 would indicate some discrepancy in these suppositions relative to development of symptoms. Five cases in which the patients had been spraying citrus are reported.

Report of Cases

Case 1. — A 20 year old Negro had sprayed with parathion for fifteen of twenty-three days prior to the time that symptoms occurred. He was using a double Boyce pressure gun and, during the fifteen day interval, he had sprayed 1,005 pounds of 15 per cent wettable parathion. He claimed to have worn an approved respirator, to have changed clothes daily, and to have bathed each night after spraying. On Oct. 11, 1950 about 7:30 p.m., he became nauseated, exhibited muscular weakness and was taken to the hospital. He was given atropine therapy and remained in the hospital twenty-four hours before dismissal. A blood sample was taken on October 13 and checked for cholinesterase levels. At that time he felt well except for slight muscular weakness. The red blood cell cholinesterase was 74 per cent and the plasma 71 per cent of normal control. On November 8, twenty-six days later, another blood sample was run. On this date the red blood cell cholinesterase was 78 per cent and the

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plasma 115 per cent of normal control. The same sample was examined for hemoglobin, which was recorded as 85 per cent. Although the plasma cholinesterase had increased from 78 to 115 per cent, the red blood cell levels had risen much more slowly than would be expected.

Case 2.—A Negro about 20 years of age had sprayed parathion with a hand gun thirteen of twenty-three days prior to the time of illness. During that time he had sprayed a total of 855 pounds of 15 per cent wettable parathion. He claimed to have worn an approved respirator, to have changed clothes daily, and to have taken a bath each night after spraying. On the night of October 11, he became ill, but remained at home during the night and went to the hospital on the morning of October 12. He was employed on the same job as the patient in case 1, but had no knowledge of his fellow worker's illness when he became sick. His major symptoms were nausea and muscular weakness. He exhibited no symptoms after entering the hospital, but was detained for twenty-four hours. On October 13 the levels of blood cholinesterase were checked, and at that time he felt well. The red blood cell cholinesterase was 70 per cent and plasma 72 per cent of normal control. On November 8, twenty-six days later, the red blood cells checked at 83 per cent and the plasma at 109 per cent of normal control. The hemoglobin estimation was 79 per cent on this date. As in the preceding case, the return of the red blood cell cholinesterase was slow.

Case 3.—A 40 year old Negro had sprayed with parathion for four days and was then off a week. He returned to spraying on a Monday morning and sprayed until Tuesday at noon. During that day and a half, he sprayed 112½ pounds of 15 per cent parathion. No record of precautions was available except that an approved respirator was supposed to have been worn. He became sick at noon and was taken to the local hospital. According to the attending physician, he was seriously ill. His eyelids twitched, and there was also a general muscular twitching. He exhibited nausea, abdominal cramps, increased heart and respiration rate with his respiration becoming shallow. He was treated with atropine and was placed in an oxygen tent for a considerable period of time. He became ill on September 15, and on September 16 a blood sample was taken for cholinesterase determinations. The red blood cells checked at 63 per cent and the plasma at 92 per cent of normal control. There was a red blood cell count of 3,300,000, and the hemoglobin estimation was 70 per cent. He was reported to have had a history of hepatic disorder. The pronounced respiratory symptoms were suggestive of parathion absorption via the respiratory tract.

Case 4.—A Negro approximately 28 years old had sprayed with parathion off and on from the first of June into August. He drove a tractor which pulled a speed sprayer. He was a member of an experimental group whose blood was being checked routinely for cholinesterase changes. On August 21, his cholinesterase values were 94 per cent and 91 per cent of normal for the red blood cells and plasma, respectively. That week the concentration of spray was changed from 5 pounds of 15 per cent wettable parathion per 500 gallon tank to 7½ pounds per tank. Eight days later, on August 29, another routine blood check was made. On this date the red blood cell level had dropped to 65 per cent, and the plasma had increased to 96 per cent of normal control. At the time the blood sample was taken, he complained of a general feeling of nausea and malaise. He sprayed one more day before reporting to a doctor, at which time his condition was diagnosed as parathion poisoning. At the time of hospitalization, he was suffering from nausea of considerable degree. No other specific symptoms were noted. On September 1 the red blood cell and plasma levels were at 67 and 93 per cent respectively. These were checked again on September 9, when they were 83 per cent and 96 per cent. The last blood check was made on September 15, and at that time the red blood cell level had decreased to 73 per cent and the plasma had remained practically the same at 95 per cent. This decrease was in spite of the fact that after August 30 no additional parathion exposure

had been experienced. By September 15 he was feeling better, but throughout a period of approximately three weeks he continually complained of a tendency to be nauseated and a general feeling of malaise. He had had no previous history of illness of any kind. This patient was grossly exposed to spray drift. He had a respirator and claimed to have worn it, but he was observed at the end of a day with his clothing saturated with spray material and his face coated with spray residue. He definitely wore clean clothes every day and bathed at the end of each day.

Case 5.—A 24 year old white man had sprayed off and on with parathion from June 10 to September 30 and had sprayed steadily except for Sundays for three weeks prior to the time that he became ill. He filled the spray tank and drove a tractor which pulled a speed sprayer. He wore an approved respirator only at the time when he placed material into the spray tank. He was careless about changing clothes regularly and taking a bath at the end of each work day. He became ill on September 30. He exhibited extreme nausea, pinpoint pupils, abdominal cramps and some slight discomfort in the chest. He was not considered to be seriously poisoned. His blood was checked on October 1, and the red blood cell cholinesterase level was 26 per cent and the plasma 34 per cent of normal control. On November 13, or after forty-four days, the red blood cell cholinesterase level was 65 per cent and the plasma level 115 per cent of normal. This patient had extreme parathion exposure over a prolonged period of time before symptoms of poisoning finally developed. Within a few days he returned to work and appeared to have no after effects at all.

Comment

These cases demonstrate that symptoms of parathion poisoning may be evidenced when plasma cholinesterase values are over 90 per cent of control and when red blood cell cholinesterase is reduced to no lower than 60 per cent to 70 per cent of normal control. In case 4, although there were initial increases in red blood cell cholinesterase after removal of the patient from parathion operations, there was a subsequent decrease without additional parathion exposure. He continued to have mild symptoms for more than two weeks after the initial ones. In cases 1 and 2, the rate of return of red blood cell cholinesterase was not as rapid as would have been expected from reports in the literature. This slow return may suggest the possibility that parathion can be retained in some tissues such as the subcutaneous lipoid layers and be slowly released over a prolonged period of time. Storage of parathion is also suggested by the fact that several other men who had parathion poisoning had trouble with vision for several weeks after all other symptoms had disappeared. Additional information is needed in order to interpret adequately the information presented here.

In case 5 there was decided reduction of cholinesterase with no previous warning symptoms. This occurrence is typical of previously published reports that ordinarily no symptoms of poisoning will be exhibited until serious reduction of chol-

inesterase has taken place. The fact that at least some workers will have warning symptoms without great reduction of blood level cholinesterase reduces occupational hazards in many instances.

In 2 cases of this series, low hemoglobin was encountered; in 1, there was a history of a disorder of the liver; and in 2 cases, red blood cell cholinesterase recovery was slow. These discrepancies may be indicative of predisposed susceptibility to parathion. They suggest the value of pre-employment examinations which would include blood protein tests for possible disease of the liver as well as cholinesterase and hemoglobin checks. It is anticipated that such examinations might well eliminate some persons who would readily become parathion poisoning casualties.

Summary

Five cases of parathion poisoning are presented. In 4 of these cases symptoms of poisoning occurred when red blood cell cholinesterase was between 50 and 75 per cent of normal control. This finding suggested that some persons will have warning symptoms before blood cholinesterase levels are seriously reduced. It is suggested that pre-employment examinations might eliminate some personnel who are predisposed to parathion poisoning.

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Drawer 873.

ACTH and Serum Sickness: Report of a Case

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Serum sickness is an allergic reaction which may appear several days after the parenteral injection of a foreign serum. The sickness is characterized chiefly by itching, urticaria, arthralgia, and malaise of varying degrees, and frequently by abdominal pain.

Biologic antisera are often used in the therapy of infection and in the prevention of certain diseases. A commonly used antiserum is tetanus antitoxin, a biologic preparation obtained from horses which is usually administered to victims of accidents, especially to those receiving penetrating wounds. This serum when given to patients for the first time may cause serum sickness. In those who have been sensitized by previous inoculation of this type of antiserum, it may cause a dangerous immediate allergic reaction or serum accident.

There are many theories as to the mechanism of serum sickness, the most widely accepted of which is based on the assumption that precipitins, skin-sensitizing and muscle-sensitizing antibodies, are formed as a result of the ingestion, inhalation or inoculation of foreign antiserum. The symptoms of serum sickness are thought to be mainly due to the union of skin-sensitizing antibodies and other fixed antibodies with the circulating antigen. These reacting antibodies usually develop from seven to twenty days following the injection of the

serum to a nonsensitized person. In persons receiving this serum for the first time, the antibodies usually reach a sufficient concentration to produce symptoms on an average in ten days. In those, however, previously injected with the same heterologous serum but no longer clinically sensitive at the time of the second injection, an accelerated form of serum sickness may develop in one to five days. If a reaction occurs immediately or within a few hours, it is classified as a serum accident, an allergic reaction similar to anaphylaxis artificially produced in lower animals. This serious reaction may occur not only in patients previously sensitized by parenteral administration of the same heterologous serum but in those spontaneously sensitive to the serum and usually to the dander of the animal from which the serum is derived. Most of these patients give a history of asthma or rhinitis from contact with animals, and such a history should be elicited before administration of an antiserum.

The symptoms and signs of serum sickness primarily involve the shock organs. These are chiefly the skin, the superficial lymph nodes, the spleen and various joints. The skin manifestations are urticaria, or urticaria and erythema, associated with itching of varying degrees. The itching itself

can become most intense. Occasionally, scarlatiniform or morbilliform eruptions occur. Purpura itself is rare. The joint manifestations vary from none to severe pain. The joints may even swell and become reddened and hot; many joints may be involved, thus producing a polyarthritis. Less common symptoms, but most striking when they do occur, are fever, edema, abdominal pain, vomiting, diarrhea, stupor and even edema of the optic disks. Occasionally, albuminuria and cylindruria may be present. The blood picture may be normal, or there may be leukocytosis followed by leukopenia and occasionally eosinophilia. Attacks usually last anywhere from one to fourteen days, and relapses may occur. Recovery practically always ensues, but many patients retain some degree of sensitiveness to the serum for years.

Until recently, the treatment has primarily consisted of the application of calamine lotion containing 1 per cent phenol to the skin, injections of adrenalin intramuscularly or subcutaneously, intravenous injections of calcium gluconate, sedatives and antihistamines.

Since the theories of Hans Selye have been enunciated, many research workers now regard serum sickness as due to an abnormal adaptive reaction. Experimental work has revealed that the destruction of antibody-forming lymphoid cells during the alarm reaction tends to prevent the development of serum sickness and other allergic conditions.

The case to be reported is one of an accelerated form of serum sickness which was treated solely with ACTH. There was an immediate response within a matter of four hours and complete subsidence of symptoms with cure within forty-eight hours after the onset of treatment.

Report of Case

Mr. C. H. S., aged 48, a masonry foreman, was injured in the right side of the chest on Oct. 2, 1950 while cutting block with a saw which flew off the machine. The injury was simple, consisting of multiple superficial abrasions, contusions and a cut over the right nipple which was closed with three sutures.

The patient was then intradermally tested with tetanus antitoxin and the sensitivity further checked by putting one drop of the antitoxin on the eye. At the end of ten minutes, there was no skin reaction nor conjunctivitis, and he was given 1,500 units of tetanus antitoxin in the right deltoid muscle.

On October 4, approximately forty-eight hours after the injection, the patient complained of severe malaise, severe frontal headache, severe nausea, lightheadedness, great weakness and an extensive rash over the site of the intradermal injection, associated with intense itching. He stated that these complaints had developed about twelve hours earlier. At that time, he related that he had received tetanus antitoxin in 1937 because he had stepped on a nail.

Physical examination showed the patient to be a short, stocky white man, approximately forty-eight years of age, who was acutely ill. His face was flushed, and both eyes, which he kept closed, were markedly suffused. The examination of the head showed the scalp to be clean, the pupils reacted to light, and the nose and throat were both clear. The examination of the chest gave essentially normal results with the exception of the injury described, and the heart and lung sounds were normal. Examination of the skin showed a diffuse mild scarlatiniform rash that was generalized. On the volar surface of the right forearm around the site of the intradermal injection, there was a large erythematous papular lesion that was approximately 3 inches wide and 4 inches long. The whole of this area was raised and reddened. In view of the extreme malaise, the patient was admitted to the Florida Sanitarium with a diagnosis of an accelerated form of serum sickness.

The laboratory work done at that time showed a hemoglobin estimation of 88 per cent, a red blood cell count of 4,900,000, a color index of .90. The white blood cell count was 9,000, the sedimentation rate was 16 mm., and the total eosinophil count was 240. Following the injection of 25 mg. of ACTH, the total eosinophil count dropped to 154 and the sedimentation rate to 10 mm.

The patient was then given ACTH, 25 mg. every six hours. Immediately following the first injection, he felt even worse than when admitted to the hospital. Directly over the site of the injection in the left buttock, the muscle began to twitch and continued twitching for one hour. Thereafter, he began to feel better and stated that he felt tired, but no longer ill. Six hours later, the second injection of ACTH was given. He again noticed a sting and twitch at the site over the injection. The third injection of ACTH was followed with only a slight twinge, and the patient stated that he felt well. Following the third injection, the intense itching began to subside. The patient's appetite returned, and his headache disappeared completely, but he was still feeling lightheaded. Twenty-four hours after the beginning of treatment with ACTH, and following the total administration of only 100 mg., the rash on the right forearm disappeared completely, and the scarlatiniform rash was entirely gone. The patient had no further complaints. Four more injections of ACTH, 25 mg., were given at six hour intervals, and then the dosage was cut to 10 mg. for three injections.

Twenty-four hours after the administration of ACTH, the total eosinophil count was 108 per cu. mm., and forty-eight hours later the total eosinophil count was down to 22 per cu. mm. Surprisingly, the sedimentation rate at the end of twenty-four hours had returned to 15 mm., and at the end of forty-eight hours had returned to 16 mm. (Westergren method). The patient was discharged as cured following the administration of 240 mg. of ACTH. Forty-eight hours later, he complained of mild reddening of the eyes, which disappeared approximately twenty-four hours later. When seen six days thereafter, he was well.

Summary

This case report deals with a case of accelerated form of serum sickness that gave immediate and spectacular response to ACTH therapy.

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Influence of Protective Urinary Colloids in the Prevention of Renal Lithiasis: Preliminary Report

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Urinary calculi are formed from crystalline and colloid* substances by a complex process which is imperfectly understood. Most investigations concerning the prevention and treatment of stone have been directed toward trying to diminish the concentration of crystalloids excreted in the urine. With the exception of correcting certain metabolic disorders, these attempts to control calculous formation have not been entirely successful. My associates and I have focused our efforts upon determining more fully the relationship of urinary colloids to the development of primary renal stones and toward preventing the precipitation of colloids and thus indirectly diminishing the formation of urinary deposits.

In the preliminary stage of this study, when an attempt was made to determine what is "normal" colloidal activity in urine, it was noted that activity of the colloids is significantly increased in pregnant women and in Negroes generally. It was also noted that colloidal activity is appreciably decreased in patients with renal lithiasis.^{1,2} The purpose of this investigation is to correlate further the possible "protective action" of the urinary colloids in the prevention of urinary calculi.

Some races are more prone to urinary lithiasis than others. The Negro is relatively immune. Vermooten³ observed that the South African Negro rarely experiences the formation of renal calculi; he found only 1 case of stone upon examination of the records of 1,090,000 Negroes admitted to the Johannesburg Hospital. At the same time, the white population of South Africa, according to the records of 126,000 patients admitted, had renal calculi in the ratio of 1 to 460 patients. Negroes in the United States are also less liable to stone formation than those of the white race. Quinland⁴ reported only 13 cases of renal stone or 0.08 per cent in 15,919 autopsies and surgical specimens

examined during a twenty-two year period in an exclusively Negro hospital. Bell⁵ noted that in 24,561 autopsies on patients of all races there were 285 or 1.2 per cent with calculi of the upper urinary tract. An analysis of 185 cases of renal lithiasis observed by us during a two year period revealed only 4 Negro patients (2.2 per cent) with renal stone. Approximately 10 per cent of patients seen by us are Negroes. Excretory radiographic studies are routinely made on all of our private and service patients. Renal and ureteral stones are considered as one disease since ureteral calculi are presumably all formed primarily in the kidney.

Calculous disease of the upper part of the urinary tract is more common in the male than in the female, the ratio varying from 1.2 to 1 to 3.4 to 1. In our series of 185 cases of renal calculi, there were 121 male patients and 64 female patients, about twice as many men as women. It was further noted that 23 (36 per cent) of the women were nulliparous. Subjects 18 years of age or younger were excluded from this series. With evidence that renal lithiasis is less common in the Negro than the white race and less common in the female than in the male sex, investigation of the possible role of protective colloids in the prevention of stone formation in these groups was carried out.

It has long been known that urinary colloids have a "protective action" tending to prevent precipitation of salts and other colloids. Litchwitz⁶ determined that the protective action of the urinary colloids belongs to a particularly high order. Urine is a hypersaturated solution, the abnormal solubility of the stone-forming salts depending upon the presence of certain colloids. Colloidal particles are considered to range in size from 0.001 μ . to 1.0 μ . (10^{-7} to 10^{-4} cm.). They may be studied by means of the ultramicroscope.

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*Derived from Greek words meaning "gluelike."

If the particles of a substance are reduced in size until the dimensions become submicroscopic and are distributed throughout a second medium, they develop characteristic properties attributable to the enormous surface area of the dispersed phase. It is estimated that one gram of colloidal material in urine has a surface area of approximately 5,000 square meters. One of the most important results of this large surface, as compared

tive action of colloids against stone formation is that sedimentation of minute particles may be almost completely counteracted by the Brownian movement of the colloidal substance.

Method of Study

Specimens of urine were obtained aseptically after cleansing the external genitalia. Female patients were catheterized to obtain the specimen, and in male patients specimens were obtained from the second glass of a two glass test. The specimens were collected in two parts. Ten cubic centimeters of urine was placed in a sterile test tube to which was added 0.25 cc. of a 25 per cent phenol solution. The tube was stoppered, and the contents of the tube were shaken briskly. The second part of the specimen was centrifugalized, then tested for pH and examined chemically for albumin and sugar. Wet sediment was examined microscopically for erythrocytes, pus cells, yeasts, fungus and crystals. The sediment was transferred to a slide, fixed with heat, stained with methylene blue, and examined for pus and bacteria.

The first specimen was used for studying "colloidal activity." This was examined under the microscope using high dry lens (x440) with dark field attachment. One drop of immersion oil was placed on the dark field condenser. A clean slide was placed in position above the condenser, and the condenser was then elevated until the oil made contact with the glass slide. One drop of urine was transferred from the test tube by means of a new, clean, wooden applicator stick to the center of the glass slide, and this was covered with a clean cover glass. The microscope was adjusted until Brownian motion was observed. Particles exhibiting Brownian motion were considered as evidence of inherent colloidal activity in the specimen as all extraneous matter, dust, small bacteria, fragmenting erythrocytes, and other artifactual materials which could produce Brownian motion were excluded. Specimens in which evidence of hematuria, infection, or albuminuria was present were discarded as it is known that fragmentation of erythrocytes, leukocytes and bacteria, and proteinuria greatly increase the free colloids present. There appeared to be no correlation between pH of the urine and the degree of colloidal activity.

Results of Examination of Urine for Colloidal Activity

Colloidal activity was graded from zero to four. Zero represented no colloidal activity; grade one minus — one to two colloidal particles intermit-



Fig. 1.— Comparison of urine obtained from subjects (A) before and (B) after parenteral administration of hyaluronidase.

to mass, is the accumulation of electrical charges at the surface and the adsorption of ions which results in the formation of an electrical field around the particles, thereby preventing their collection into larger aggregates.⁷ A localized accumulation of colloidal material may collect around a crystal, forming a pellicle or membrane, which prevents agglutination and consequent crystal growth. Another important factor in the protec-

tently present in the field; grade one — one to five particles constantly present in the field; grade two — six to ten particles per field; grade three — eleven to twenty particles per field; and grade four — over twenty particles per field. One hundred ninety-eight specimens were examined. It was observed that colloidal activity was elevated in 32 of 41 (78 per cent) pregnant women as compared to 15 of 41 (36.6 per cent) nonpregnant women. Of 36 Negro patients, 25 (69.4 per cent) had elevated colloidal activity as compared to 11 of 36 (30.5 per cent) white patients with elevated colloidal activity. Of 22 specimens of urine obtained from white patients with single primary renal or ureteral calculi, there were 6 (22.2 per cent) with zero colloidal activity; 15 (68.2 per cent) with grade one activity; and only one (4.5 per cent) with elevated colloidal activity. Of 22 white patients without calculi, 9 (40.9 per cent) had elevated colloidal activity as compared to 13 (59.1 per cent) with grade one or normal colloidal activity.

Our clinical observation that frequently urine did not sediment when obtained from patients receiving parenteral fluids to which hyaluronidase* was added (fig. 1), suggested that this drug may be useful for increasing the protective urinary colloids. Following the subcutaneous injection of 0.2 mg. (150 TRU) hyaluronidase dissolved in 1 cc. of saline, it was noted that colloidal activity of urine was significantly increased in 16 of 20 (80 per cent) subjects studied. Further comparisons of degree of colloidal activity in different groups of

subjects and the effects of hyaluronidase on these subjects is being carried out in collaboration with Dr. Ernst Hauser, Professor of Colloid Chemistry, Massachusetts Institute of Technology and the Wyeth Institute of Applied Biochemistry.

Summary

Observation of colloidal activity in urine revealed that it is appreciably elevated in pregnant women and Negroes generally and decreased in patients with renal stones as compared to control groups. These facts suggest that differences in "protective colloidal activity" are the reason why renal calculi are less common in women than in men and less common in the Negro than in the white race. They also may explain why in certain persons deficient in this protection, stones develop in the urinary tract. Preliminary studies reveal that hyaluronidase injected subcutaneously significantly increased the colloidal activity in urine in 16 of 20 subjects examined.

*Hyaluronidase (Wydase) was generously supplied by Wyeth Laboratories, Philadelphia.

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1101 North Palafox Street.

ABSTRACTS OF MEDICAL ARTICLES

THE CONSEQUENCES OF THE SURGICAL RELIEF OF URETEROVESICAL OBSTRUCTION. By Louis M. Orr. J. Urol. 63. 1043-1052 (June) 1950.

Two cases are reported which presented problems relating to dilatation of the upper part of the urinary tract due to obstruction at the ureterovesical junction. In both, the patient was operated upon with the purpose in mind of widely opening the lower end of the ureters, thus producing a situation which would allow not only for complete emptying of the upper part of the urinary tract, but for regurgitation of the vesical contents up the ureters, which was presumed to be expected following such a procedure.

The operative procedure is described. While similar to that of Ritter and Kramer in principle, it provides for greater permanency of results by the placement of indwelling ureteral catheters and more precise suturing of the enlarged orifice.

The author concluded that "the surgical correction of ureterovesical obstruction is the production of vesicorenal reflux as a consequence." He observed that while this condition is unphysiologic, the cases reported show that the reflux is not incompatible, subjectively and objectively, with apparent good health and that the benefits derived from the relief of the obstruction may no doubt possibly outweigh the potential damage wrought by the reflux.

COMMON CAUSES FOR UNSATISFACTORY RESULTS IN ENDOSCOPIC PROSTATIC RESECTION. By Joseph C. Hayward, James B. Glanton and Louis M. Orr. *J. Urol.* 64:114-120 (July) 1950.

These authors deplore the far too many unsatisfactory results following endoscopic prostatic resection despite the great advance in both instrumentation and technic especially in the last decade. They regard surgical inaptitude as the commonest cause, for this operation is perhaps the most difficult to master in all genitourinary surgery. Other causes cited include incomplete resection of the adenomatous tissue; injury to the external sphincter muscle with the resulting incontinence, complete or partial, the most distressing complication; and stricture formation, particularly involving the external urethra meatus and the anterior urethra, the most frequent complication.

A series of 470 cases of obstructive prostatic disease in which the patients were treated surgically during the three years prior to May 1949 forms the basis for this resume of the experience of the authors. Included in the series were many winter residents of Orlando who had previously received surgical treatment in other clinics and hospitals.

The indications for and the technic of endoscopic prostatic resection are discussed. The authors regard this operation as the most abused of all surgical procedures, but they also observe that adequate endoscopic resection, technically most difficult for the surgeon, is nevertheless from the patient's viewpoint the most desirable approach to the obstructive prostatic lesion. They conclude that a continuation of unsatisfactory results is to be expected unless urologists electing to do endoscopic resections are thoroughly trained and adept in such surgery.

FACTORS IN THE RATE OF DEVELOPMENT OF VASCULAR LESIONS IN THE KIDNEYS, RETINAS AND PERIPHERAL VESSELS OF THE YOUTHFUL DIABETIC. By Howard F. Root, M.D., Richard H. Sinden, M.D., and Ralph Zanca, M.D. *Am. J. Digest. Dis.* 17:179-186 (June) 1950.

A report is made of a series of 282 cases in which the incidence of vascular lesions in the kidneys, retinas and peripheral vessels of patients with onset of diabetes between the ages of 15 and 30 years was studied with special reference to the duration of diabetes and the character of control of diabetes. Control was considered poor in

the presence of coma one or more times, abnormal blood sugar values and urine tests, infrequent medical examinations and no insulin therapy within a year of the onset of diabetes. Fair control implied the early use of insulin, cooperation on the part of the patient in carrying out urine tests frequently and having fairly regular blood and urine tests with examinations by a physician.

In patients observed over a twenty year period, the incidence of retinal lesions including retinitis proliferans was much reduced in those patients with fair control in contrast to those with poor control. Roentgen evidence of calcification of peripheral vessels or of the pelvic vessels increased with the duration of diabetes and with the lack of diabetic control. Nephritis, present in 51 cases, did not occur before the tenth year of diabetes except in 5 instances. The authors observed that intercapillary glomerulosclerosis is more common and more malignant in young diabetic patients of long duration than in later life and is therefore related to the severity of the diabetes.

Of 56 patients with diabetes of twenty to twenty-nine years' duration, in 24 per cent only slight traces of calcification in arteries occurred, and in 12 per cent none was noted.

LONG-TERM DICUMAROL THERAPY TO PREVENT RECURRENT CORONARY ARTERY THROMBOSIS. By E. Sterling Nichol, M.D., and Joseph F. Borg, M.D. *Circulation* 1:1097-1104 (May) 1950.

The authors report a series of 78 cases in which the patients continued to receive dicumarol therapy indefinitely following an attack of acute coronary thrombosis and/or myocardial infarction in the hope of preventing recurrent attacks. Encouraging results ensued over periods up to five years. The 12 fatal cases are briefly reviewed, in only 4 of which acute coronary thrombosis recurred. The hemorrhagic complications encountered are analyzed. It is shown that ambulatory treatment is feasible if patients are painstakingly followed.

The necessity of meticulous accuracy in prothrombin determinations is stressed. It was necessary, even after months of treatment, to determine the prothrombin time at 7, 10 or 15 day intervals, depending on the "stability" of the patient.

LOW DOSAGE PITUITARY-OVARIAN IRRADIATION IN SECONDARY AMENORRHEA AND ASSOCIATED STERILITY. By Charles J. Collins, M.D. South. M. J. 43:527-531 (June) 1950.

Dr. Collins analyzes the results of a poll of gynecologists regarding their opinion and experience with low dosage irradiation to the pituitary gland or ovaries in the treatment of secondary amenorrhea. From 410 replies to his questionnaire he learned that only about 30 per cent of the gynecologists of the United States have used this therapy, and after studying the causes of disapproval concluded that the majority of the fears expressed are more fancied than real.

He presents a series of 70 cases, observed over a period of ten years, which illustrate the results of treatment with irradiation. Also, he discusses the significance of the increased number of pregnancies in the patients who responded successfully to this treatment, the danger of the treatment and the possible harmful effects in the series. The results with supplemental cyclic steroid therapy are given.

The technic of the treatment is outlined. In addition, the contraindications to the treatment and the type of case most adaptable for treatment are indicated. Stress is placed on the necessity of eliminating the possibility of an early pregnancy before treatment and on the importance of the administration of the therapy by an experienced roentgenologist.

ALLERGY AND THE HEART IN CLINICAL PRACTICE. By Clarence Bernstein, M.D., F.A.C.A., F.A.A.A., and S. D. Klotz, M.D. Ann. Allergy 8:336-344 (May-June) 1950.

A study of clinical syndromes involving the heart, either by connotation or by direct reference, led these authors to conclude that much care is needful in confirming many diagnoses of cardiac ailment and that a high index of suspicion for allergic factors may be the means of avoiding tragic repercussions for the patient and his family in a small but definite proportion of cases characterized by complaints of cardiac origin or implication. A series of such cases is presented which demonstrates prompt, dramatic and at times lasting relief when selected cases are managed allergically. Even when the allergy is but a contributory cause to the breakdown of an already physically or mentally overburdened patient, its proper treatment often brings gratifying reward.

SCREWORM (*COCHLIOMYIA AMERICANA*) INFESTATION IN MAN. By H. Marshall Taylor, M.D. Ann. Otol., Rhin. & Laryng. 59:531-541 (June) 1950.

A series of 8 cases of infestation of the nasal cavity by the screwworm (*Cochliomyia americana*) is reported. There was one fatality from meningitis, one narrow escape from death owing to massive and repeated nasal hemorrhages, and one instance in which a saddle nose developed with almost complete loss of the soft palate from cicatricial atresia of the nasopharynx and a fistula in the maxillary antrum extending through the soft tissues of the cheek. In these cases the disease was in the late stages when the patient was first seen.

The common site of infestation in man is the nose; infestation of the nasal sinuses, pharynx, throat, mouth, ear, orbit, eyeball and open wounds may, however, also take place. A pre-existing pathologic condition of the nose is the chief predisposing factor. A cut, scratch or abrasion of the skin attracts the female screwworm fly, which is a shiny, bluish green blowfly, distinguished from the ordinary bluebottle fly by three longitudinal black stripes symmetrically arranged on the thorax. After being deposited in a favorable environment, the eggs hatch out in twenty-four hours. Sleeping in the open invites infestation.

Partial obstruction to breathing on the affected side and a feeling of discomfort associated with a peculiar sensation at the root of the nose which becomes an intense pain are cardinal symptoms. At first, sneezing may occur, and severe headache may persist. With the onset of an accompanying serosanguineous nasal discharge of offensive odor, there may be repeated clearing of the throat, frequent expectoration, and the coughing up of a purulent material which may contain living or dead larvae.

The larvae are removed by mechanical means or by the use of drugs. The drug of choice is chloroform, applied locally and as a vapor. The author is of the opinion that the mortality in rhinal myiasis would be relatively as high in man as it is in livestock if the disease were allowed to remain untreated. Screwworm infestation occurs chiefly in the South, but cases of human infestation with this parasite have been observed as far north as Illinois and Missouri. Such cases were first reported in Florida in 1937 by this author.

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All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1951.

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All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1951.

May Anniversaries

MAY 1. René Théophile H. Laënnec, born in Brittany in 1781 and recognized as one of the keenest observers in clinical medicine of the early nineteenth century, invented the stethoscope on May 1, 1819. His famous treatise on mediate auscultation, which appeared that same year, revolutionized physical diagnosis of the chest and allowed him to rise to fame within a few years. He became professor of medicine at the College de France when only 41 years of age. A victim of pulmonary tuberculosis, he died four years later of the disease which he had helped many physicians diagnose more accurately.
MAY 4. Thomas Henry Huxley of London was born on May 4, 1825. As a surgeon in the Royal Navy, he studied biology on a long research voyage in the South Pacific. Skilled in making accurate observations and noted for his good judgment, Huxley popularized the teaching of science and soon entered into active defense and support of Darwin and his new doctrine of evolution. While

Darwin was of retiring nature and modest disposition, Huxley was aggressive and unusually clever in making his arguments clear and sharp. Self-styled "Darwin's bulldog," he loved a good fight, but never bore malice toward anyone. He made important contributions to comparative anatomy and biology, but, more important, he defended and championed veracity of thought and accuracy of observation as far as one was able, no matter to what heterodoxy it might lead.

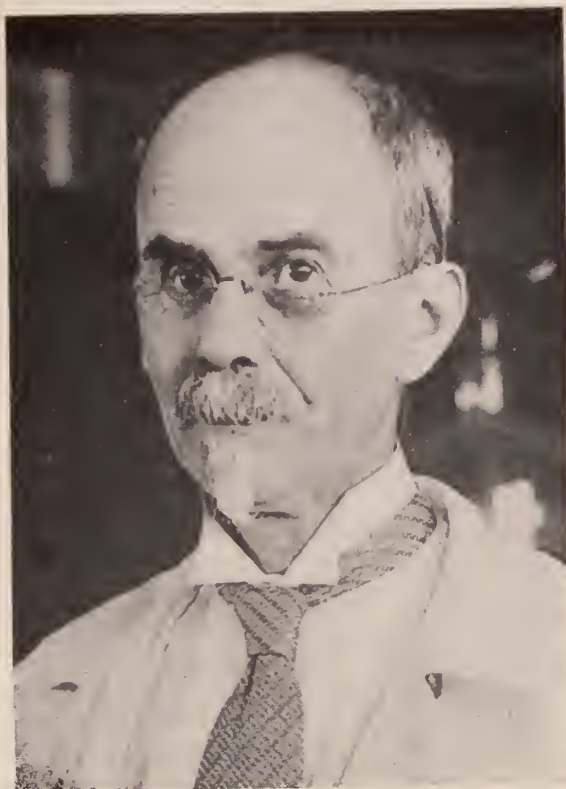
MAY 6. Sigmund Freud of Vienna, born on May 6, 1856, made an important contribution to abnormal psychology when he directed attention to the subconscious, especially with regard to repressed sexuality. He inaugurated the use of psychoanalysis as a diagnostic instrument. A controversial figure largely because of his emphasis on sex during an age of taboo, Freud had many disciples from abroad, but was little noticed in his home city, Vienna. Few today will deny the importance of his contributions to psychiatry, particularly in "Anxiety Neuroses," published in 1895. When the Nazis entered Vienna and burned his books, Freud from his haven in London stated: "At least I have been burned in good company."

MAY 11. Helena, mother of Emperor Constantine, is believed to have founded the first Christian hospital when Constantine closed the pagan temples in 335. Justinian, born May 11, 483, erected new buildings for this hospital, which was located at Caesarea in Cappadocia and named in honor of St. Basil.

MAY 14 and 17. Edward Jenner of Berkeley, England, was born May 17, 1749. A pupil and friend of John Hunter, he made a major contribution to English Medicine by carefully studying and experimenting upon vaccination against smallpox. The first person whom he vaccinated was William Phipps. The date was May 14, 1796. His famous "Inquiry" was published in 1798. It is hard for those who have enjoyed protection from smallpox for a century and a half to realize that prior to Jenner, approximately one quarter of the population died of smallpox; the rest became scarred.

MAY 19 and 26. John Jacob Abel of Baltimore was born on May 19, 1857 and died May 26, 1938. For nearly forty years he was professor of pharmacology at the Johns Hopkins School of Medicine and after his retirement from teaching he became director of the Laboratory for Endocrine Research. Epinephrine, the active principle of the adrenals and the first active constituent to be separated from an endocrine gland, was isolated by Dr. Abel in 1898. His studies of histamine, hormones of the pituitary gland and tetanus were pioneer contributions. He was the first to use dyestuffs as test materials of the functional efficiency of various organs and with his co-workers was the first to isolate insulin and bufagin in crystalline form. Useful in various types of investigation is his ingenious method of vividiffusion, permitting isolation of amino acids directly from the blood. With Cushny he founded the Journal of Pharmacology and Experimental Therapeutics and served as its editor from 1909 to 1932. Among the many pupils through whose work his influence continues are Reid Hunt, D. I. Macht and L. G. Rowntree.

Dr. Abel lived simply. He asked for nothing better than to continue his research and informal teaching until the end of his life. In his laboratories, the student assistants who worked with him during his later years continued to be amazed at his drive and delighted to listen to him talk while they prepared tea, toast and jelly for him at the lunch hour. Dr. Abel, the father of American pharmacology, used to say that "we are walking drugstores." He was a walking dynamo and lovable genius. He worked until about the time of his eighty-first birthday. One week after that birthday he died.



John J. Abel.

Motives for Studying Medicine

Against the background of a half century which saw universal peace give way to universal war, security to insecurity, certainty to fear, and the ideal of progress to the doubt of survival, there looms the figure of a physician, international in stature, whose life is the supreme exemplification of self dedication to human welfare. Albert Schweitzer belongs not alone to the spirit of Aesculapius, but likewise to the ages, to the spirit of Jesus and St. Paul, and to the spirit of Johann Sebastian Bach. Across the centuries and across the world into the very heart of suffering in the Dark Continent, he pitched a blazing torch which has penetrated the darkness of our civilization. From his African jungle hospital he surveyed the shambles of the Europe he had left and wrote his critique of modern civilization, not alone in his great phrase, "Reverence for Life," but even more emphatically in his incarnation of it.

In the light of such a life, what are the dominant motives driving medical students to their arduous discipline today? A survey of the current freshmen at the University of Illinois College of Medicine gives a gratifying answer to the charges of greed and selfishness frequently made against the medical profession. This study revealed self dedication to human welfare as still a dominant motive in holding young men and young women to the difficult eight years of training and the rugged demands of general practice.

It is heartening for the future of American medicine and the health of the nation that one-third of the 166 freshmen students — a capacity class — were motivated by such altruistic, humanitarian motives for entering medicine as desire to help the less fortunate, to better the world, to conquer disease, or to decrease suffering. Medicine to them is “far more than a mere occupation. . . . a life devoted to the service of mankind.”

Interest in science inspired one fourth of the applicants. One sixth had cherished from childhood the desire to be a doctor. A like number were motivated by admiration for the family doctor or for a relative who was a physician. One could wish that there had been more than the single member of this group motivated by the heroic figure of Albert Schweitzer. A small number turned to medicine through sympathy aroused by watching parents or friends through an illness. A few recorded a divine call to the life of a medical missionary, and half a dozen mentioned scientific curiosity.

Only 12 of the 166, or one fourteenth, listed a desire to make money, and only 8, or less than one twentieth, coveted the prestige of the physician. Even these, however, revealed a high concept of the healing art. They pictured the doctor as “a respected man with an infallible character, scrupulous morals and high ideals,” who has “security, happiness and contributes to society.”

These data were compiled by Dr. Carroll L. Birch, Professor of Medicine at the University of Illinois College of Medicine, and the results of his study were reported recently in the Illinois Medical Journal. As members of the medical profession ponder these motives with pardonable pride, they may well contemplate the far reaching influence they may have on some of those preparing to be their successors in the practice of their beloved profession.

The Safe Use of DDT

Now that the season for fighting insects around the home, at camps and other recreation centers, and on farms is well under way, many are turning to DDT. This powerful insect killer, developed during World War II, has come to have wide application in agriculture, medicine, public health and commercial sanitation. Its importance to public health was emphasized in 1948 when the Nobel Prize in medicine was awarded to Paul Müller, the Swiss chemist who discovered its entomologic properties.

When used wisely, this essentially poisonous material can be used safely. Some human deaths have resulted from its use, but in general its poisonous effect decreases with the increasing complexity of the living organism exposed to it. Insects are destroyed by its apparent peripheral action; in man and higher animals, it is a “cerebrospinal” poison acting primarily on the central nervous system. Such disturbances of the central nervous system as hyperexcitability, generalized tremors, spastic or flaccid paralysis and convulsions constitute the principal systemic effects in higher animals. Although it is an inherently toxic material, it nevertheless has a wide margin of safety when judiciously used because mammals absorb relatively little of it.

As an insecticide, DDT is used both as a contact and a stomach poison. Its action, primarily on the nervous system of the insect, is slower than that of many chemicals, and it therefore lacks rapid paralyzing effects. Its prolonged action, however, and the small amounts required increase its value. Unfortunately, the time has not yet come to abandon the flyswatter for some species of insects, notably houseflies and certain mosquitoes, have developed a tolerance or resistance to this preparation.

Reporting on the pharmacologic and toxicologic aspects of DDT in the March 10 Journal of the American Medical Association, the Committee on Pesticides of the Council on Pharmacy and Chemistry of the American Medical Association warned that while human beings and the higher types of animals are “not likely” to be harmed, certain precautions must be observed to guard against its potential toxic properties.

Farmers were warned that DDT applied directly to the edible portions of a plant may result in poisoning. It should not be used on dairy cattle

or animals being prepared for slaughter, since there is danger of accumulation of the substance in the milk and tissues of treated animals.

Other precautions suggested by the committee include:

"DDT insecticides should never be stored in food cupboards or medicine chests where there is likelihood of contamination of food or mistaken use. All exposed foods, utensils and working areas must be covered when kitchen and dining areas are being sprayed.

"Children's toys or cribs and rooms occupied by sick people should not be sprayed.

"Use of oil solutions on household pets should be avoided and DDT powders should be used only where they cannot be licked off. Intimate skin contact with aerosol discharge is to be avoided. Plants and aquariums in the home should be removed or covered before applying DDT sprays or aerosols.

"The use of oil solutions in the vicinity of open fires should be avoided because of the inflammability of such mixtures. . . .

"Persons exposed to large amounts of DDT dusts and powders under confined conditions or where dust particles are not carried away by free movement of air currents should wear respirators. . . .

"Frequent or prolonged exposure to emulsions or solutions of DDT in petroleum oils and organic solvents should be avoided unless protective clothing, goggles and neoprene or solvent-resistant gloves are worn. . . .

"Operators involved in large scale spraying or fogging with solutions of 5 per cent or more of DDT should wear respirators and other protective devices. . . ."

The Pharmacist Looks At Socialized Medicine

Although some pharmacists believe that socialized medicine would be of financial benefit to them, they do not want it. If a patient were to require medication under such a system, they figure, the physician would write a prescription and the patient would have to obtain the medicine from a pharmacy. The physician's set fee would not cover the cost of drugs, and he would therefore not be able to dispense the medicines he prescribes, as some physicians are doing today, nor would he be able to charge for them, should he decide to dispense them.

The pharmacists believe they would not run into conflict with the refill laws under government-controlled medicine because the patient would know that a new prescription would be necessary every time he received medicine. This requirement would naturally more than double the work of the physician.

The remedies prescribed would of course have to be of such nature as to insure the lowest possible cost to the government. The pharmacist would therefore be able greatly to reduce the overhead of the prescription department by less duplication of trade name items and more compounding from drugs and chemicals which pharmacies normally have to carry. The pharmacists believe the over-all influence would result in an increase in the volume of prescriptions with a greater net profits to the pharmacies.

On the other hand, the members of this closely allied profession believe that physicians would be so restricted in their medical practice that the best in medical care could not be given. By having their professional charges at a set figure, by having a certain number of patients or a fixed area assigned to them, and by being restricted to the use of certain types of drugs, physicians would be so handicapped in their practice that they could not give individualized care and appropriate treatment to their patients. They could not, therefore, practice medicine in the best public interest.

The pharmacists, therefore, do not want socialized medicine, even though they would gain by it financially, because they are convinced it would hinder the public health. Most of the public, now educated against it by pharmacy and medicine, do not want it. Both, however, could easily change their attitude if some physicians do not personally do something about it themselves.

Throughout the state, representative pharmacists aver, there are some physicians who are leading themselves and their profession into socialized medicine, although they are spending their money, time and effort against the trend. The reasons cited include making high charges to people who cannot afford them and who are the loudest talkers; prescribing certain types of medicines, usually high-priced ones, with the demand that the patient return for a refill in order to get another office fee; charging twice for a home or office call if the physician talks to professionally or prescribes for two persons in the same family; using injectable medication and charging an exorbitant fee in excess of the office or home fee for the in-

jections; charging excessive fees for an examination and laboratory work; selling medicines and contraceptive devices; exhibiting a superior attitude; giving the patient the impression that he is the subject of experimentation, and, last but by no means least, appearing to place the dollar mark above interest in the patient.

Physicians who unwittingly, carelessly or otherwise engage in practices and cling to attitudes detrimental to their profession and therefore to themselves, could in the eyes of the pharmacists and the public eliminate much feeling by carefully evaluating appropriate charges, by prescribing drugs for compounding, by purchasing drugs through the drug store, by refraining from dispensing, by writing prescriptions according to the letter of the law without playing favoritism, and by nurturing a wholesome psychologic reaction in the patient.

Candor undoubtedly has its place in constructive criticism. There may be some physicians in Florida who will wish to evaluate themselves professionally through the eyes of well meaning pharmacists, staunchly fighting the battle against socialized medicine side by side with physicians.

Course on Hematology June 21-23, 1951

The Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health will present a course on Hematology on June 21-23, 1951 at the George Washington Hotel in Jacksonville.

Dr. Charles A. Doan, Dean, Professor of Medicine and Director of Medical Research of the Ohio State University College of Medicine, Columbus, Ohio, will present the lectures, which will begin at 2 p.m. on Thursday, June 21, and continue until noon on Saturday, June 23. Dr. Doan, who was one of the familiar team which started out under Dr. George Minot in Boston a number of years ago, is one of the most outstanding hematologists in the world today. Although the program is as yet not complete, it is anticipated that Dr. Doan will discuss such topics as hemophilia, familial jaundice, splenomegaly, indications for bone marrow studies, leukosarcoma, and treatment of blood dyscrasias, as well as other subjects stressing the clinical aspects together with blood studies and laboratory data.

Registration for this course may be made in advance. Registration will also be open to well qualified laboratory technicians who have been certified by the head of the laboratory of a private physician and whose background or practical training is sufficient to make the course profitable to them. Tuition for the course will be \$25.00 for physicians and \$10.00 for technicians. For further information address the Director, Department of Medicine, Graduate School, University of Florida, 1009 Stockton Street, Jacksonville 4.

Nineteenth Annual Graduate Short Course June 25-30, 1951

The Nineteenth Annual Graduate Short Course will be held at the George Washington Hotel in Jacksonville, June 25-30, 1951. The faculty is as follows:

Medicine: Dr. Chester S. Keefer, Wade Professor of Medicine, Boston University School of Medicine, Boston.

Pediatrics: Dr. S. F. Ravenel, Dean of the Southern Pediatric Seminar at Saluda, Greensboro, N. C.

Obstetrics: Dr. William J. Dieckmann, Professor of Obstetrics and Gynecology, University of Chicago, The School of Medicine, Chicago Lying-In Hospital, Chicago.

Diseases of the Chest: Dr. David T. Smith, Professor of Bacteriology and Associate Professor of Medicine, Duke University School of Medicine, Durham, N. C.

Poliomyelitis: Dr. Robert J. Neville, Director of Orthopedic Services, The National Foundation for Infantile Paralysis, New York City.

Surgery: Dr. William A. Altemeier, Assistant Professor of Surgery, University of Cincinnati College of Medicine, Cincinnati.

Gynecology: Dr. Andrew A. Marchetti, Professor and Chairman of the Department of Obstetrics and Gynecology, Georgetown University School of Medicine, Washington, D. C.

It is hoped that the physicians who attend this Short Course will bring their wives with them. Adequate entertainment will be furnished.

The complete schedule is presented on the opposite page.

SCHEDULE OF THE SHORT COURSE

HOUR	Monday June 25	Tuesday June 26	Wednesday June 27	Thursday June 28	Friday June 29	Saturday June 30
8:00	Registration					
9:00	Diseases of the Chest "Primary Tuberculosis" Dr. Smith	Pediatrics "Poliomyelitis" Dr. Ravenel	Pediatrics "The Treatment of Asthma" Dr. Ravenel	Obstetrics "Abortions — Nutrition — Anemia — Rh Factor Sterility" Lecture — Discussion	Gynecology "Comments on the Problems of Infertility and Sterility" Dr. Marchetti	Gynecology "Preoperative and Postoperative Care in Gynecology" Dr. Marchetti
10:00	Pediatrics "Prophylaxis and Treatment of Acute Infectious Diseases" Dr. Ravenel	Diseases of the Chest "Reinfection Tuberculosis" Dr. Smith	Medicine "Fluid Replacement Therapy" Dr. Keefer	Dr. Dieckmann	Obstetrics "Prolonged Labor" Lecture — Discussion Dr. Dieckmann	Surgery "Surgical Treatment of Diverticulitis of the Colon" Dr. Altemeier
11:00	Recess	Recess	Recess	Recess	Recess	Recess
11:30	Medicine "A Discussion of Pain, Its Mechanism and Control" Dr. Keefer	Pediatrics "Practical Pediatric Pointers" Dr. Ravenel	Pediatrics "Gastrointestinal Diseases" Dr. Ravenel	Surgery "Treatment of Wounds of Violence" Dr. Altemeier	Surgery "Surgical Lesions of the Spleen" Dr. Altemeier	Gynecology "The Anatomy and Correction of Uterine Prolapse" Dr. Marchetti
12:30	Lunch	Lunch	Lunch	Lunch	Lunch	Surgery "Tumors of Small Intestines" Dr. Altemeier
2:00	Pediatrics "Acute Nephritis" Dr. Ravenel	Medicine "Cortisone, Further Observations" Dr. Keefer	Medicine "The Interpretation of Laboratory Tests in Common Use" Dr. Keefer	Gynecology "The Management of Uterine Malpositions" Dr. Marchetti	Obstetrics Toxemia of Pregnancy — Treatment — Immediate Results and Late Sequelae" Lecture — Discussion Dr. Dieckmann	
3:00	Recess	Recess	Recess	Recess	Recess	
3:15	Medicine "Antibiotics" Dr. Keefer	Diseases of the Chest "Bacterial and Viral Infections of the Lungs" Dr. Smith	Obstetrics "Hemorrhage — Heart Disease — Surgical Complications" Lecture — Discussion	Surgery "Problems and Principles in Newer Uses of Antibiotics" Dr. Altemeier	Surgery "Intestinal Obstruction" Dr. Altemeier	
4:15	Recess	Recess		Recess	Recess	
4:30	Diseases of the Chest "Fungus Diseases of the Lungs" Dr. Smith	Medicine "Management of Patients with Heart Failure" Dr. Keefer	Dr. Dieckmann	Gynecology "Office Diagnosis and Treatment of Lesions of the Vulva and Vagina" Dr. Marchetti	Gynecology "Carcinoma of the Cervix" Dr. Marchetti	
	Dinner	Dinner	Dinner	Dinner	Dinner	
8:00	Diseases of the Chest "Progress in the control of Tuberculosis" Dr. Smith	Poliomyelitis "Poliomyelitis — Recent Advances and Treatment" Dr. Neville		Surgical Round Table		

**MOUNT SINAI HOSPITAL
OF GREATER MIAMI
FIRST ANNUAL SEMINAR PROGRAM**

May 23, 1951

David A. Nathan, M.D., Department of Medicine,
Presiding

9:00 A.M.

Opening Address: Mr. Max Orovitz,
President, Board of Trustees

9:05 A.M.

Address of Welcome:
A. R. Hollender, M.D.,
President, Medical Advisory Board

9:10 A.M.

Opening Seminar: Milton S. Saslaw, M.D.,
Chairman, Seminar Committee

9:15 - 10:05 A.M.

Biophysical Methodology and Its Application
to Medical Research

*John W. Gofman, M.D., Associate Professor of
Medical Physics, University of California, Berkeley*

10:10 - 11:00 A.M.

Physiology and Physio-Pathology of Peripheral
Vessels

*David I. Abramson, M.D., Chief, Peripheral Cir-
culatory Clinic, Michael Reese Hospital, Chicago.*

Richard M. Fleming, M.D., Department of Surgery,
Presiding

11:20 - 12:10 P.M.

Pathology of Arteriosclerosis

*Otto Saphir, M.D., Director of Pathology, Michael
Reese Hospital, Chicago*

12:15 - 1:15 P.M.

Panel Discussion (Entire Faculty)

Morris H. Blau, M.D., Department of Surgery, Presiding

2:15 - 3:05 P.M.

Peripheral Vascular Disorders: Methods of
Study

*Charles W. Robertson, M.D., Associate Visiting
Surgeon, Massachusetts Memorial Hospitals, Bos-
ton*

3:10 - 4:00 P.M.

The Effect of Electrolyte Alterations on the
Heart with Particular Reference to the Effect
of Hyper- and Hypopotassemia

*Samuel Bellet, M.D., Associate Professor of Car-
diology, Graduate School of Medicine, University
of Pennsylvania, Philadelphia*

Julius R. Pearson, M.D., Department of Medicine,
Presiding

4:20 - 5:20 P.M.

Panel Discussion (Entire Faculty)

7:30 P.M.

Cocktail Party

8:30 P.M.

Informal Banquet

"The Plumber and the Doctor"

Milton S. Saslaw, M.D.

Operation for Coronary Artery Disease

*Claude S. Beck, M.D., Professor of Neurosurgery,
Western Reserve University School of Medicine,
Cleveland*

May 24, 1951

Max Dobrin, M.D., Department of Medicine, Presiding

9:00 - 9:50 A.M.

Studies of Arteriosclerosis Utilizing Biophysi-
cal Approaches

John W. Gofman, M.D., California

9:55 - 10:45 A.M.

Collagen Alterations in Rheumatic Heart
Disease

Otto Saphir, M.D., Chicago

Paul N. Unger, M.D., Department of Medicine, Presiding

11:05 - 11:55 A.M.

The Circulation and Metabolism of the Human
Brain in Health and Disease

*Seymour S. Kety, M.D., Professor of Clinical
Physiology, Graduate School of Medicine, Uni-
versity of Pennsylvania, Philadelphia*

12:00 - 1:00 P.M.

Panel Discussion (Entire Faculty)

Leonard Rowntree, M.D., Department of Medicine,
Presiding

2:00 - 2:50 P.M.

Functional Vascular Diseases

David I. Abramson, Chicago

2:55 - 3:45 P.M.

Peripheral Vascular Disorders: Methods of
Treatment

Charles W. Robertson, M.D., Boston

Victor H. Kugel, M.D., Department of Medicine, Presiding

4:05 - 4:55 P.M.

Treatment of Cardiac Arrhythmias with Par-
ticular Reference to the Use of Recent Ther-
apeutic Agents

Samuel Bellet, M.D., Philadelphia

5:00 - 5:45 P.M.

Panel Discussion (Entire Faculty)

May 25, 1951

Louis Lemberg, M.D., Department of Medicine, Presiding

9:00 - 10:00 A.M.

Cerebral Circulation — Demonstrated by

*Seymour S. Kety, M.D., Philadelphia
Peritz Scheinberg, M.D., Research Associate, Uni-
versity of Miami Medical Research Unit*

10:00 - 11:00 A.M.

Collagen Vascular Diseases

Louis Lemberg, M.D.

11:00 - 12:00 Noon

Surgical Demonstration

Rudolph E. Drosd, M.D., Dept. of Surgery

Registration limited to 200.

Registration Fee is \$20.00 (Includes Cocktail Party and
Banquet).

Interns and Residents Fee \$7.00 (Includes Cocktail Party
and Banquet).

Mount Sinai Hospital Seminar

The first annual medical seminar of the Mount Sinai Hospital of Greater Miami will be held at Miami Beach, Florida, on May 23, 24 and 25, 1951. This seminar will deal with recent advances in cardiovascular diseases — medical and surgical aspects.

A cordial invitation is extended to all Florida physicians to come to Miami to attend these meetings and to enjoy a short vacation at the same time. The committee is especially eager to have the wives of the physicians come along and a program of special events has been arranged for them.

The scientific sessions will be held at the Sorrento Hotel at Miami Beach. This will include two sessions on Wednesday, May 23; two sessions on Thursday, May 24; and one session on Friday, May 25, 1951.

The non-scientific activities will include golfing at the Bayshore Golf Club, the Normandie Isle Golf Club and the Miami Shores Golf Club; fishing parties; swimming parties; sightseeing tours of the Greater Miami area, including the Everglades. A special theatre party for the wives of physicians on the evening of the Scientific Banquet has been arranged at the University of Miami.

Hotel accommodations may be obtained. Registration Fee of \$20.00 including Cocktail Party and Banquet. Fee for interns and residents is \$7.00 which includes the Cocktail Party and Banquet.

For information contact Dr. Milton S. Saslaw, chairman of the Seminar Committee, 4300 Alton Road, Miami Beach 40, Florida.

Sharing Vital Knowledge Through Medical Textbooks

In Thailand CARE representatives recently found professors and students making mimeographed copies of the few precious medical textbooks on hand. The lack of needed medical books seriously handicaps these university students, for they are entirely dependent upon lectures for their basic knowledge and cannot be assigned home reading and preparation for laboratory or classroom work.

As a means of sharing vital knowledge, American physicians are being urged by CARE to chan-

nel new American medical books to Thailand and twenty-three other countries in Europe and Asia through its CARE-UNESCO Book Fund, 20 Broad St., New York City, or any local CARE address.

Israel, Indo-China and the Malay States have just been added to the list of countries whose medical schools and libraries can be helped through the plan. Cash contributions in any amount are welcomed. On donations of \$10 or more, donors may specify the kind of book, country and specific medical institution or type of institution they want to help. CARE makes delivery in their name and returns a receipt giving the name of the recipient institution.

YOUR BLUE SHIELD

Blue Shield Record for 1950

For the benefit of Blue Shield physicians who were not able to attend the annual Blue Shield meeting in Hollywood Beach on April 22, here are a few of the highlights of the Plan's record for 1950.

ENROLLMENT increased by 53,281 new members in 1950, bringing total enrollment as of December 31, 1950, to 203,783.

PHYSICIAN PARTICIPATION in Florida Blue Shield numbered 2,115 by the end of 1950.

CLAIMS FOR BLUE SHIELD BENEFITS numbered 31,883 in 1950.

PAYMENTS TO PHYSICIANS in 1950 amounted to \$1,153,391.81 and \$171,596.35 was accrued for unpaid claims which were being processed, as compared to 1949 payments and accruals of \$661,531.10 and \$88,520.85 respectively.

ANALYSIS OF 1950 PAYMENTS TO PARTICIPATING PHYSICIANS (Cases actually paid — not incurred cases).

Physicians Paid	Amount Paid
1044	Under - \$ 500
233	\$ 500 - 1,000
187	1,000 - 2,000
81	2,000 - 3,000
30	3,000 - 4,000
19	4,000 - 5,000
5	5,000 - 6,000
6	6,000 - 7,000
4	7,000 - 8,000

OPERATING EXPENSES for 1950 amounted to 14.60% of income — a reduction of 0.47% over 1949.

NET INCOME of \$147,134.55 was added to Reserves for Contingencies in 1950 as compared to net income of \$158.75 added to reserves in 1949.

NEW MEMBERS

The following doctors have joined the State Association through their respective County Medical Societies.

Bell, Arlis G., Miami Springs
 Cowdery, John S., Jacksonville
 Crankshaw, Daune W., Lake Placid
 Daffin, Sidney E., Panama City
 Daversa, Joseph J., West Palm Beach
 Davis, Carl H., Miami
 Hall, Young L., Jr., Miami
 Hankins, I. Sylvester, (Col.), Orlando
 Holzer, Oswald A., Chattahoochee
 Jennings, John L., Jr., Palmetto
 Jones, Millard F., Jacksonville
 LaCour, Bennett J., Jr., Daytona Beach
 Madden, Edward P., Daytona Beach
 Peschio, Daniel D., Fort Lauderdale
 San, James M., Tampa
 Welsh, Robert C., Miami

STATE NEWS ITEMS

Florida doctors registered at the New Orleans Graduate Medical Assembly, March 5-8, are as follows: Drs. John E. Granade, Bradenton; Irving T. Clark, Chattahoochee; William G. Mason, Clearwater; Rabun H. Williams, Eustis; Scottie J. Wilson, Ft. Lauderdale; Fred D. Bartleson and Marion F. Johnson, Ft. Myers; Hugh B. Goodwin, Jr., Ft. Pierce; Chester F. Ahmann, John E. Maines, Jr., Harry M. Merchant, Gainesville; Laurie J. Arnold, Jr., and Thomas H. Bates, Lake City; James T. Cook, Jr., Marianna; Julius Alexander, Lassar Alexander and C. Russell Morgan, Miami; Thos. H. Wallis, Ocala; Morton Levy and Abraham H. Spivack, Orlando; Gustav N. Click, Rudolph P. Stritzinger, and Carol C. Webb, Pensacola; Harry R. Deane, Edward V. Pollard and John B. Woodville, Jr., St. Petersburg; Joseph D. Sclaro, Edward F. Shaver and Burdette Smith, Tampa; John J. Scanlon, Winter Garden, and Wiley T. Simpson, Winter Haven.

Dr. Gerald W. Jones of Orlando has returned to his practice following the completion of a post-graduate course at Emory University School of Medicine in Atlanta.

Dr. Frank G. Slaughter of Jacksonville on March 24 was the guest speaker at a meeting of the St. Petersburg Woman's Club. Dr. Slaughter chose as his subject, "Why We Behave Like Children and Vice Versa."

Dr. Irwin S. Leinbach of St. Petersburg recently spoke over a local radio station on cerebral palsy, its cause and how to treat it.

Miami area doctors who participated in a program of the American Physicians Art Association for the Miami Art League included: Drs. Carl E. Dunaway, Anna A. Darrow, Manning J. Rosnick and Robert T. Spicer.

Dr. Arthur J. Butt, Pensacola, is currently carrying on research work on the influence of protective urinary colloids in the prevention of renal lithiasis which is attracting national attention. The Wyeth Laboratories, Philadelphia, has awarded a research grant to the Butt-Douglas Research Foundation for clinical and laboratory investigation which is to be performed by Dr. Butt.

The purpose of this grant is to investigate further the following: (1) the role of protective colloids in the prevention of urinary tract stone; (2) the effect of hyaluronidase in increasing protective urinary colloids and thereby combating the formation of concretions in the urinary tract; and (3) the role of hyaluronidase in basic tissue and fluid metabolism.

This work is being carried out in collaboration with Dr. Ernst A. Hauser, Professor of Colloid Chemistry, Massachusetts Institute of Technology, Cambridge, and Worcester Polytechnic Institute, Worcester, Mass., and Dr. Joseph Seifter, Director of Research, Wyeth Institute of Applied Biochemistry.

The preliminary report of Dr. Butt's research work appears in the scientific section of this Journal. Dr. Butt presented additional information resulting from this research at the meeting of the Southeastern Section of the American Urological Association in Memphis, March 7-10.

Dr. William H. McCullagh of Jacksonville, in the month of February, spoke on mental health to the local Pilots Club and the Mental Hygiene Society of Northeastern Florida.

Dr. Walter B. Tomlinson of Warrington, in the early part of March, addressed the local Civitan Club on the general subject of heart disease.

Dr. J. Rocher Chappell of Orlando, chairman of the F.M.A. Committee on Advisory to Selective Service for Physicians and Allied Specialists, was the guest speaker at the March meeting of the Orange County Dental Society. Dr. Chappell explained the functions and organization of local medical, dental, veterinarian and allied fields in connection with civil defense.

Dr. James L. Borland of Jacksonville, chairman of the F.M.A. Committee on Emergency Medical Service, attended state civil defense meetings in Miami in February.

Dr. Alphonsus M. McCarthy of Daytona Beach recently discussed the medical aspects of the atomic bomb at a meeting of a voluntary air reserve training squadron at the local airport.

Mr. Leo E. Brown, Chicago, assistant to the Secretary and General Manager of the A.M.A. and in charge of the Department of Public Relations, was a recent visitor to the headquarters office where he conferred with Association officers.

President White asked the following members to meet with Mr. Brown: David R. Murphey, Jr., president-elect; Robert B. McIver, secretary-treasurer; Joseph S. Stewart, chairman of the committee on public relations; Eugene B. Maxwell, and Stewart Thompson.

Dr. James V. Freeman of Jacksonville recently addressed a local Dads' Club on the organization of civil defense.

Dr. M. S. Hernandez of Miami is serving a residency in obstetrics and gynecology at the University of Kansas Medical Center.

Dr. Cecil M. Hogan of Jacksonville has returned to his practice following attendance at clinics at the Emory University School of Medicine in Atlanta.

Dr. Edward R. Annis of Miami recently addressed the local North Shore Heights Woman's Club on the subject, "The Issue of Public Health Insurance."

Dr. Cornelius A. Bird of Jacksonville was guest speaker at the Eighth District Meeting of the Medical Society of Georgia on April 3 in Waycross, Georgia. He read a paper on the treatment of head injuries.

Dr. G. Frederick Oetjen of Jacksonville, chairman of the Committee on Representatives to Industrial Council, represented the Association at the recent meeting of the American Medical Association Industrial Council in Atlanta. Dr. Oetjen reports that consideration is being given to industrial health policies as they relate to the civil defense program.

Dr. George W. Edwards, II, of Orlando has been appointed health officer of the city of Orlando succeeding the late Dr. Jos. P. Williamson.

The following Florida doctors were registered at the recent meeting of the Southeastern Section of the American Urological Association which was held in Memphis: Drs. David W. Goddard, Daytona Beach; Russell B. Carson, Ft. Lauderdale; George H. Putnam, Gainesville; John R. Browning and Robert B. McIver, Jacksonville; Jack A. McKenzie, James J. Nugent, Saul J. Pearlman and Frank M. Woods, Miami; Louis M. Orr, II, Orlando; Arthur J. Butt and Lee Sharp, Pensacola; Abraham J. Gorday, St. Petersburg; Henry L. Smith, Jr., Tallahassee; Louis A. Spicola, Tampa, and Edwin W. Brown, West Palm Beach. Dr. Carson was re-elected secretary-treasurer for the ensuing year.

COMPONENT SOCIETY NOTES

Broward

The Broward County Medical Society sponsored an open forum in late February on the subject of "The Doctor, the Hospital and the Community." Dr. Edward R. Annis of Miami was the principal speaker. City and county officials, as well as business and professional men, participated in the meeting.

Dade

Guest speaker at the April 3 meeting of the Dade County Medical Association was Dr. Donald Guthrie of Sayre, Pennsylvania. The subject of Dr. Guthrie's address was "The Diagnosis and Treatment of Surgical Lesions of the Breast."

Duval

Dr. Russell Hedley Morgan, chief radiologist at the Johns Hopkins Hospital, was the guest speaker at the regular monthly meeting of the Duval County Medical Society on April 3. Dr. Morgan's topic was "The Use of X-Ray in Congenital Heart Disease."

Hillsborough

"The Modern Trend in the Treatment of Tuberculosis" was presented to the Hillsborough County Medical Association at its April meeting by Dr. Henry C. Sweany, medical director of the State Tuberculosis Board, who has his headquarters in Jacksonville.

Madison

All members of the Madison County Medical Society have paid 1951 state dues.

Marion

The Marion County Medical Society, at its March meeting, had as its guest speaker, Mr. Reginald Giles, former General Motors consulting engineer. Mr. Giles' remarks were based on experiences during the bombing of London in World War II. He answered questions from the members on communism and socialism in various parts of the world.

Orange

The Orange County Medical Society has elected an official recorder, Dr. W. Dean Steward of Orlando, who reports the activities of the society and its members to the State Association. Dr. Steward has been serving in this capacity since the first of the year.

Pinellas

"Some Radiological Aspects of the Colon" was the subject of discussion at the April meeting of the Pinellas County Medical Society. This scientific program was in charge of Dr. John P. Ferrell, St. Petersburg.

Volusia

At the regular March meeting of the Volusia County Medical Society, Dr. George F. Schmitt of Miami read a paper on "The Management of the Heart Failure Patient."

OBITUARIES**Paul Temple Butler**

Dr. Paul Temple Butler of Orlando died in a local hospital on Jan. 4, 1951. He was 92 years of age.

The son of Hiram and Lydia Eliza Butler, Dr. Butler was born in Springboro, Pa., on Dec. 11, 1858. He attended Valparaiso University and completed his medical training at Eclectic Medical College in Cincinnati in 1880.

For nearly forty years Dr. Butler practiced medicine in Kalamazoo, Mich. The last twenty-seven years of his life were spent in Orlando, nineteen of them in active practice. When he retired at the age of 85, he had handled approximately 3,000 childbirth cases and had attended more than 350,000 patients during the sixty-three years he had engaged in active practice.

A pioneer in surgery, Dr. Butler was one of the first surgeons to tie the common carotid artery, and was the first surgeon in Michigan to operate for ectopic pregnancy and also the first to perform a completely successful vaginal panhysterectomy. He also won medical recognition for research with cobra and rattlesnake venom in the treatment of arthritis and was the author of two books.

Like his father before him, who was one of Pennsylvania's first state representatives, Dr. Butler was particularly interested in government. Soon after coming to Florida, he drafted a charter for Winter Park patterned after the one in use in Kalamazoo, where he had served four terms as city commissioner, and that charter remains essentially the same today. Later he was active in the effort to keep Orlando public utilities from private control.

A member of the Orange County Medical Society, Dr. Butler was also a member of the Florida Medical Association, holding honorary status for eight years, and of the American Medical Association.

Surviving are the widow, Mrs. Charlotte Butler, of Orlando; three sons, Ben H. Butler of Sacramento, Calif., and Robert B. Butler and Donald W. Butler, both of Orlando; one daughter, Mrs. A. L. Sikkenga, of Orlando; one sister, Mrs. Helen B. Strait of St. Cloud; and two grandchildren.

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—Selesnick, S.: *The Treatment of Amebiasis*, Connecticut M. J. 12:946 (Oct.) 1948.

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The previous belief that the high specific dynamic action of protein imposes excessive demands on the heart of the hypertensive patient has also been discredited clinically. Curtailment of the protein intake below that needed for metabolic requirements depletes body protein reserves, leads to excessive weakness, interferes with many immunologic reactions, and often is a factor in anemia or in its intensification.² Rather than an indication for restricting protein, albuminuria in hypertensive disease is an indication for determining whether the patient's protein intake should be increased to compensate for urinary losses.

In hypertension, the aim of the diet is to provide optimal amounts of protein, vitamins and minerals and to maintain the hypertensive patient at normal weight. By increasing the work of the already overburdened heart, obesity renders the patient more vulnerable to the hazards of hypertension. When weight reduction is indicated, lean meat may well be the mainstay of the dietary regimen. For patients requiring restriction of sodium, only unsalted meats should be used.

Furnishing large amounts of biologically complete protein, muscle meat can contribute valuably to the protein requirements of the hypertensive patient. But meat represents much more than just an excellent protein food. It also provides valuable amounts of iron and the B complex vitamins, including niacin, pyridoxine, riboflavin, thiamine, and the newly discovered vitamin B₁₂.

(1) Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, J.A.M.A. 142:409 (Feb. 11) 1950.

(2) Stieglitz, E. J.: Hypertensive Arterial Disease and Hypotension, Chapter 30, Geriatric Medicine, The Care of the Aging and the Aged, 2nd ed., Philadelphia, W. B. Saunders Company, 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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Elsmere Rife Rickard

Dr. Elsmere Rife Rickard of Tampa died unexpectedly of a heart attack on Jan. 16, 1951 in Ft. Myers while on a business trip to that city. He was 50 years of age.

Dr. Rickard was born on Feb. 1, 1900 in Weeping Water, Neb. His father was a physician, Dr. Edward T. Rickard, and his mother was Lydia Rife Rickard. Dr. Rickard obtained his premedical training at the University of Nebraska and the degree of Doctor of Medicine from Northwestern University Medical School in 1924. He interned at Cook County Hospital in Chicago. He received his Master's degree in Public Health from the Johns Hopkins School of Hygiene and Public Health in 1935.

In 1925, Dr. Rickard joined the Rockefeller Foundation. Early in his career he had been engaged in hookworm and malaria control in Paraguay and yellow fever research in Brazil and Colombia. In 1936 he began research on influenza, which he conducted first in the laboratories of the International Health Division of the Rockefeller Foundation in New York and from 1943 to 1945 in Minneapolis, in cooperation with the Department of Health of Minnesota. He made several surveys of typhus in the Southern states and was assigned to the Florida State Board of Health for typhus research in 1946. Dr. Rickard set up a laboratory at Drew Field to carry out this work, which was a cooperative project of the Rockefeller Foundation and the Florida State Board of Health.

During World War II Dr. Rickard was a member of the Commission on Influenza of the Board for the Investigation and Control of Influenza and other Epidemic Diseases in the United States Army. In 1941 he went to Bermuda at the invitation of the colony's Governor and the medical departments of the United States Army and Navy to study an outbreak of dengue fever and advise concerning mosquito control measures.

Dr. Rickard was the author of thirty scientific papers dealing with infectious diseases, particularly yellow fever, influenza and marine typhus.

He was a member of the Hillsborough County Medical Association, the Florida Medical Association and the American Medical Association. He was also a member of the American Public Health Association.



From where I sit
by Joe Marsh

Wrong Powder For Hunting

Seldom see Jackson the forest ranger—or ex-forest ranger—around these parts any more. He's retired now, on a pension.

Ran into him, though, over at Harpersbury, yesterday. Still hale and hearty—doesn't look half his age. He makes extra money guiding campers and hunting parties. Told me about something that happened to him on his last trip.

"We lost our way, back of Ten Mile River," he says. "And when I reached for my compass to check up, I found I'd brought the wife's compact by mistake! I used the sun to find the river, and we finally got out—but I sure felt like a real greenhorn . . ."

From where I sit, this shows how even the experts can get mixed-up at times. Take the way some "experts" would deny us the right to a glass of beer—or the way still others would like to tell a man how to practice his profession. I say they're experts only at minding somebody else's business!

Joe Marsh

Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman¹ deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache — its character, laterality, frequency and intensity.²

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic: analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b. p. level; Dihydroergotamine relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g.i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,³ and Friedman, A. P.⁴

Cecil⁵ ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

- 1) *Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.*
- 2) *Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.^{1,6} The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

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Besides his widow, Mrs. Jessica B. Rickard of Tampa, he is survived by a daughter, Miss Norma Jeanne Rickard of San Gabriel, Calif.; his mother, Mrs. Lydia Rife Palmer of Los Angeles; and a brother, Edward T. Rickard of Torrence, Calif.

Joseph Patterson Williamson

Dr. Joseph Patterson Williamson of Winter Park died at his home on Feb. 2, 1951, following an illness of several months. He was 50 years of age. Interment took place in Ware Shoals, S. C.

Born at Macon, Ga., on Oct. 26, 1900, Dr. Williamson received his academic training at Wofford College in Spartanburg, S. C., and in 1928 was awarded the degree of Doctor of Medicine by the Medical College of the State of South Carolina at Charleston. Entering the general practice of medicine at Ware Shoals, S. C., the following year, he practiced there for twenty years, majoring in pediatrics, and was medical director for the Riegel Textile Corporation in that city for a number of years.

In 1949 he located in the Orlando area and on March 1 of that year was appointed city physician and health officer for Orlando. For nearly two years he served in that capacity and was instrumental in inaugurating a health card examination program for all food handlers which was considered by health officials one of the best in the state. Dr. Williamson was a member of the staff of the Orange Memorial Hospital. Locally he was also a member of the Civitan Club and the American Legion, having served as a captain in the Medical Corps of the United States Army during World War II. He was a Mason and a member of the Methodist Church.

Dr. Williamson was a member of the Orange County Medical Society, the Florida Medical Association and the American Medical Association. He also held membership in the Phi Chi medical fraternity.

Surviving are the widow, the former Miss Jennie C. Gasque of Latta, S. C., whom he married in 1929; one son, Joseph P. Williamson, Jr.; two daughters, June and Janet Williamson; and his mother, Mrs. Lillian Redding, all of Winter Park.

James Leonidas Estes

Dr. James Leonidas Estes of Tampa died at his home on Feb. 10, 1951 after a prolonged illness. He was 55 years of age. Interment took place at Myrtle Hill Memorial Cemetery in Tampa.

Born in Gay, Ga., on Feb. 5, 1896, Dr. Estes was the son of W. N. Estes and Blanche Thrash Estes. He received his premedical training at Oxford College (Little Emory) in Georgia and the degree of Doctor of Medicine from Emory University School of Medicine in 1921. He interned at Cook County Hospital in Chicago from 1921 until 1923.

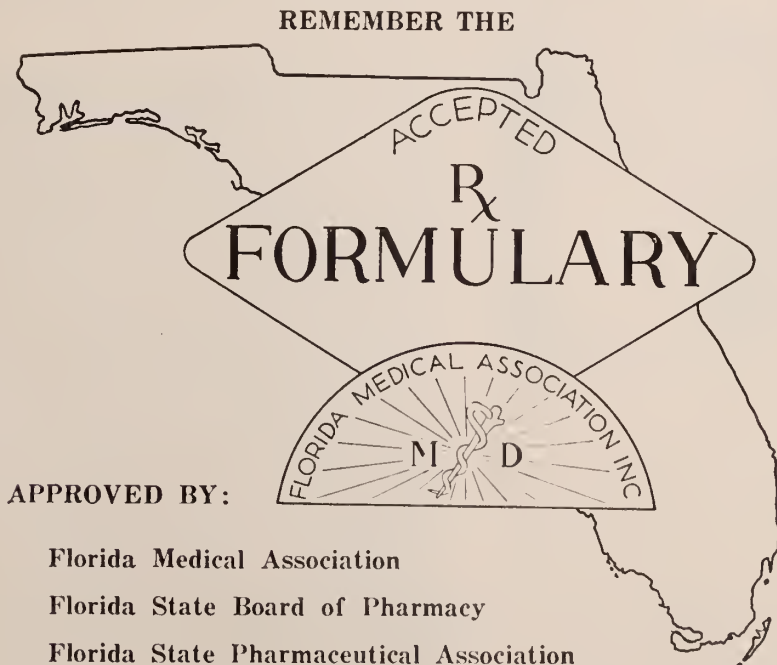
Dr. Estes practiced medicine in Atlanta, Ga., from 1923 until 1925, at which time he started practice in Tampa. He took numerous postgraduate seminars in urology. He was a staff member of the Tampa Municipal Hospital, St. Joseph's Hospital and the Clara Frye Tampa Municipal Negro Hospital.

During World War I, Dr. Estes was commissioned as a first lieutenant in the United States Army, but was deferred to complete his medical education. During World War II, he was an examiner for the Selective Service Board.

Dr. Estes took an active part in athletics and was physician for both the University of Tampa and the Hillsborough High School teams. He was a director of the local chapter of the American Red Cross. A member of St. Andrews Episcopal Church, he also held membership in Egypt Temple Shrine, Tampa Elks Lodge No. 708, Royal Order of Jesters, Ye Mystic Krewe of Gasparilla and the Palma Ceia Golf Club.

A member of the Hillsborough County Medical Association, Dr. Estes was also a member of the Florida Medical Association, in which he served on several important committees during the twenty-five years of his membership, including at the time of his death the Committee on Venereal Disease. In addition, he was a member of the American Medical Association, the Southern Medical Association, the Florida Urological Association, the Southeastern Urological Association, the American Urological Association, and the American Venereal Disease Association.

Surviving are the widow, Mrs. Mays Sandford Estes; a daughter, Mary Eleanor; two sons, Stephen Sandford and James, Jr., all of Tampa; three brothers, Royce N. Estes of Gay, Ga., Hughlett



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H. Estes of Atlanta, Ga., and Joseph T. Estes of Chattanooga, Tenn.; and two sisters, Mrs. H. G. Banister of Ila, Ga., and Mrs. J. B. Hutchinson of Senoia, Ga.

Gideon Timberlake

Dr. Gideon Timberlake of St. Petersburg died suddenly at his home on March 1, 1951. He was 73 years of age.

Born in Charlottesville, Va., in 1876, Dr. Timberlake was educated in his native state. In 1902 he received the degree of Doctor of Medicine from the University of Virginia Department of Medicine in Charlottesville.

A noted urologist and inventor of several urologic instruments, Dr. Timberlake was a major in the Medical Corps of the United States Army in World War I. For some time he served as chief of the Department of Urology of Walter Reed Hospital in Washington.

After the war, Dr. Timberlake became Professor of Urology at the University of Maryland School of Medicine and College of Physicians and Surgeons in Baltimore. In 1926 he was licensed to practice medicine in Florida and two years later located in St. Petersburg, where he practiced throughout the remainder of his professional career.

Dr. Timberlake was a fellow of the American Medical Association and for more than two decades held membership in the Pinellas County Medical Society and the Florida Medical Association. He was also a member of the American Urological Association and the American College of Surgeons.

Surviving are the widow, Mrs. Sallie Virginia Helms Timberlake; two daughters, Mrs. Brandon Taylor of Spartanburg, S. C., and Mrs. William Haymaker of Atlanta, Ga.; and one brother, Crawford Timberlake of Hartsville, S. C.



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BOOKS RECEIVED

PDR, PHYSICIANS' DESK REFERENCE TO PHARMACEUTICAL SPECIALTIES AND BIOLOGICALS, 1951. By J. Morgan Jones, Editor and Publisher. Pp. 632. Rutherford, N. J., Medical Economics, Inc., 1951.

The fifth issue of PDR (Physicians' Desk Reference — 1951) is now being distributed free to over 125,000 practicing physicians in the United States through the courtesy of the manufacturers whose major products are described under professional products information in Section IV (White). Section I (Pink) is an alphabetical index; Section II (Yellow), a drug, chemical and pharmacological index; Section III (Blue), a therapeutic indications index; and Section V (Green), a compendium of general professional information. This valuable reference index is produced and distributed annually to physicians without charge to enable them to keep pace with the changes in formulas and the appearance of new drugs and new specialty products.

CANCER AS I SEE IT. By Henry W. Abelmann, M.D. Pp. 100. Price, \$2.75. New York, Philosophical Library, 1951.

This book sets forth the arguments for the author's theory that cancer has a germ-virus nature. It is written for the laity as well as the medical profession.

THE MICROKARYOCYTES, THE FOURTH CORPUSCLES AND THEIR FUNCTIONS. By K. G. Khoroizian, A.B., M.S., M.D. Pp. 969, illus. 480. Price, \$12. Boston, Meador Publishing Company, 1951.

As stated in the preface, the main and only topic of this work deals with the discovery of so far unknown and undescribed corpuscular or cellular elements universally present in the plasma, blood cells and tissue cells of different species and different phyla of animate matters from the lowest to the highest, and with the descriptions of the various, important and biologically and physiologically indispensable functions performed by them.

These elements are designated microkaryocytes, meaning cells with the smallest nuclei so far known to exist or described.

CALLING ALL PARENTS. By the Bureau of Health Education, American Medical Association. Price, 25 cents. Pp. 26.

This exceedingly attractive booklet is a special pamphlet of the Bureau of Health Education of the American Medical Association. It is elaborately illustrated with pictures of babies which tell their own story, each of which is annotated with a brief word to parents. There is also a list of suggested readings for parents whose children are yet in the first decade of life.

In quantities the pamphlet may be purchased at prices ranging from \$2 for 10 copies to \$4.50 for 25; \$8 for 50; \$12 for 100; \$27.50 for 250; \$50 for 500; and \$90 for 1,000.

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NOTICE

Old officers and committee chairmen appear in this May Journal since it went to press before the election of officers at the annual meeting, April 23. New officers and committee chairmen will appear in your June Journal.

Medical Family Reunion

One of the nicest events of the year in any State is its medical family reunion. Those who attend ours each year with the desire to understand the workings of the Association, to meet other Florida doctors, and to broaden with its scientific panels, develop a deep feeling of pride, loyalty and affection.

It is certainly a state-wide family reunion because it is the one time all doctors can meet. The responsible men in this medical family gather to discuss and solve the current problems which affect the whole.

Like all reunions, however, serious as the underlying reasons may be, the atmosphere is one of gaiety and warmth because friends from different counties have a chance to visit and the hotel is like a huge house-party.

It's a wholesome, inspiring occasion to see the many men and women who come with the thought of meeting to work for closer unity as well as to further progress for the future of the whole state.

As in all groups, of course, there are some who are selective in what they consider to be of value to themselves, but in time, the merest observer will find himself an active participant. When the doctor is inspired by this slice of Americana, this working together to build for the future, his wife becomes aware of the Auxiliary group and we are furthered that much more.

We became really united under the clouds of a crisis, as have many neighbors who have lived together for years without discovering the necessity of personal relationship which develops when they work together to batten down for a storm. Though the winds and rains and clouds may pass away, the friendships made in times like these endure. Courage is gained from the warmth of these friendships to face another threat; courage, as well as a new perspective.

In the flashes of lightning that slash across a darkening sky, familiar things are defined because they are singled out by threat. In the political storm clouds which hovered over medicine we discovered our inadequacies and, in so doing, found ourselves.

Mrs. C. Robert DeArmas
President.

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to Be Published

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GYNECOLOGY—Intensive Course, Two Weeks, starting June 18, September 24. Vaginal Approach to Pelvic Surgery, One Week, starting June 11, September 17. **OBSTETRICS**—Intensive Course, Two Weeks, starting June 4, September 10.

MEDICINE—Intensive General Course, Two Weeks, starting October 1. Gastroenterology, Two Weeks, starting October 15. Gastroscopy, Two Weeks, starting July 16. Electrocardiography & Heart Disease, Two Weeks, starting July 16. Liver & Biliary Diseases, One Week, starting June 4.

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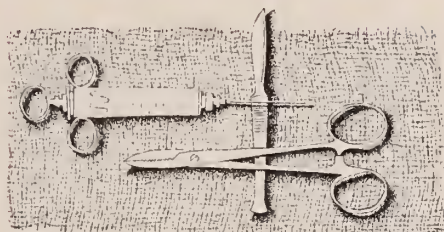
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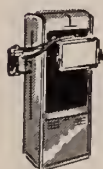
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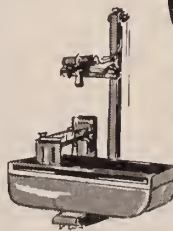
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	David R. Murphey, Jr., Tampa		
Florida Medical Districts	Lloyd J. Netto, W. Palm Beach	Council Chairman	
A-Northwest	Taylor W. Griffin, Quincy	Arthur J. Butt, Jr., Pensacola	Pensacola, 1951
B-Northeast	Cleland D. Cochrane, Daytona Beach	Eugene G. Peek, Jr., Ocala	Orlando, 1951
C-Southwest	M. Crego Smith, Clearwater	Leldon W. Martin, Sebring	Bradenton-Sarasota, 1951
D-Southeast	S. Marion Salley, Miami	Adrian M. Sample, Ft. Pierce	Vero Beach, 1951
Florida Specialty Societies			
Academy of General Practice	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	
Anesthesiologists, Soc. of	Ralph S. Sappenfield, Miami	Adelbert F. Schirmer, Orlando	
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	
Derm. and Syph., Soc. of	Wesley W. Wilson, Tampa	Morris Waisman, Tampa	
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	
Pathological Society	Nelson A. Murray, Jacksonville	Gretchen V. Squires, Pensacola	
Pediatric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	
Proctologic Society	Edward C. Watt, Jacksonville	George Williams, Jr., Miami	
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 2, '51
Blood Banks, Association	William C. Thomas, Gainesville	James M. McClamroch, Gainesville	
Dental Society, State	D. Morrison, Sr., D.D.S., Gainesville	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando
Hospital Service Corporation	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando
Medical Examining Board	William C. Thomas, Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, June 24-26, '51
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
Public Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	
Woman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.		
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Houston, Texas, Dec 4-7, '51
Southern Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loran, Birmingham	Dallas, Texas, Nov. 5-8, '51
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	
S. E. Hospital Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	
Southeastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	Augusta, Ga., Mar. 21-22, '52
Southeastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	
Southeastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
Gulf Coast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss., October, '51

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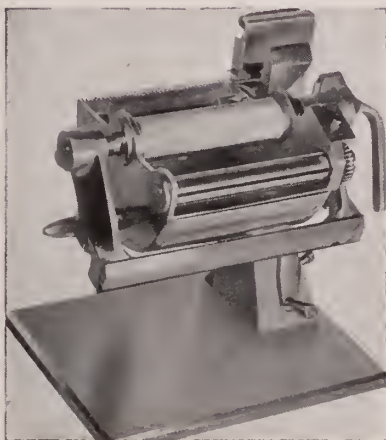
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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	James M. Nixon, M.D. 825 Jenks Ave. Panama City	Harold E. Wager, M.D. Box 984 Panama City		22	18	A-1-52 Arthur J. Butt, M.D. Pensacola
	Escambia *Santa Rosa	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	73	10	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	6	5	
	Jackson *Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	11	
	Walton-Okaloosa	Arthur G. Williams, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	14	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	1	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	12	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	51	47	
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	7	
	Madison	Julian M. Dukant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	100%	
	Taylor *Dixie-Lafayette	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	1	221
B	Alachua *Bradford, Gilchrist, Union	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	47	45	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
	Duval *Clay	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	245	183	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	28	23	
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Claude M. Knight, M.D. 121 Madison St. Palatka	James W. Brantley, M.D. Grandin	2nd Tuesday 6:00 P.M.	10	9	
	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	14	B-4-53 Eugene L. Jewett, M.D. Orlando
	Brevard	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	19	18	
	Lake *Sumter	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	25	21	
	Orange *Osceola	Fred Mathers, M.D. 314 American Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	146	131	
	Seminole	Thomas F. McDaniel, M.D. 315 Magnolia Ave. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	13	12	
C	Volusia *Flagler	Peter A. Drohomier, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	69	57	627
	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	159	141	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	14	
	Pasco-Hernando- Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	13	11	
	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	181	170	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	38	C-6-52 Leldon W. Martin, M.D. Sebring
	DeSoto-Hardee- Highlands- Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Edwin C. Northup, M.D. Box 98 Avon Park	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte- Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	25	23	
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	85	72	
							552
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	104	88	
	St. Lucie- Okeechobee- Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	17	13	
	Broward	M. Austin Lovejoy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	69	D-8-53 Donald W. Smith, M.D. Miami
	Dade	Jack O. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	560	378	
	Monroe	Ralph Herz, M.D. 420 Simonton St. Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	10	8	778

*Supervise and aid until organized separately.

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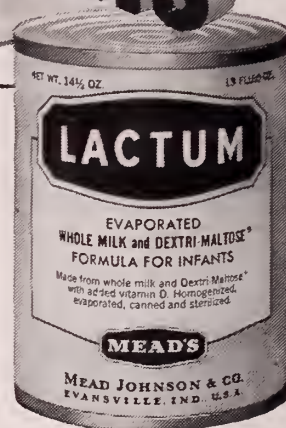
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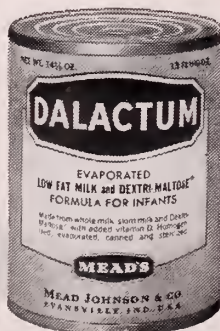
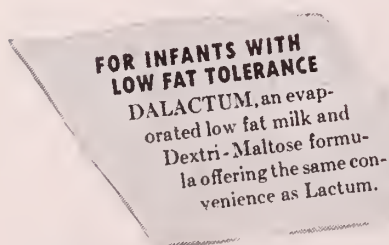
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OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVII

JUNE, 1951

No. 12

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IN THIS ISSUE

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House of Delegates Actions
Scientific Assemblies
General Sessions



President's Address

Herbert E. White



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OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION



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CHLOROMYCETIN's world-wide reputation stems from its ability to produce rapid, clinical response in a wide variety of infectious diseases — bacterial, viral and rickettsial. Numerous reports and the experience of daily practice confirm its

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Two recent reports on SOPRONOL therapy establish its value.

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1. Nettleship, A.: Arch. Dermat. & Syph. 61:669, 1950
2. Brewer, W. C.: Arch Dermat. & Syph. 61:681, 1950

Sopronol therapy is a therapy of choice with physician after physician.

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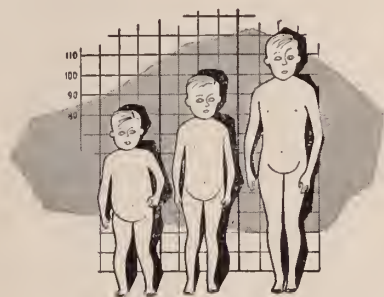
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Sodium caprylate	10.0%	Zinc caprylate	5.0%	Sodium caprylate	10.0%
Zinc caprylate	5.0%	Inert ingredients	75.0%	Dioctyl sodium	
Dioctyl sodium				sulfosuccinate	0.1%
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Inert ingredients	69.9%			including n-Propyl	
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*Effective against many bacterial and rickettsial infections,
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Capsules: Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.
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Meat . . .

in the Low-Sodium Diet

Clinical experience^{1,2} and investigative data³ indicate that the liberal use of meat may not be contraindicated when sodium intake must be restricted. Because unsalted meat contains only relatively small amounts of sodium, while contributing importantly to other nutrient needs, meat deserves special consideration in very-low-sodium diets, in sodium-poor diets, and in no-extra-sodium diets.

Table I lists the amounts of sodium³ in three kinds of meat. Table II gives the estimated amounts of sodium in hospital diets planned for cardiorenal vascular patients.⁴

SODIUM IN MEAT³

	Sodium Provided by 60 Gm. Serving	Sodium Provided by 100 Gm.
Beef, without bone	32 mg.	53 mg.
Lamb, without fat	66 mg.	110 mg.
Pork, without fat	35 mg.	58 mg.

Table I

SODIUM IN HOSPITAL DIETS⁴

Sodium-Poor Diets*				Very-Low-Sodium Diet†
40 Gm. Protein	70 Gm. Protein	100 Gm. Protein	130 Gm. Protein	70 Gm. Protein
400 mg. Na	500 mg. Na	800 mg. Na	1,000 mg. Na	200 mg. Na

Table II

*Foods prepared and served without salt.

†Weighed diet. May contain 4 oz. of unsalted meat.

(Normal diets contain approximately 4 Gm. of sodium daily.)

Hence, the data here shown indicate that relatively generous amounts of meat may be included in low-sodium diets.

Meat serves well in the therapeutic objective of maintaining a high state of nutrition in patients with congestive heart failure or nephritic edema by providing valuable amounts of biologically complete protein and of B complex vitamins, including the recently discovered B₁₂.

1. Wheeler, E. O.; Bridges, W. C., and White, P. D.: Diet Low in Salt (Sodium) in Congestive Heart Failure, *J.A.M.A.* 133:16 (Jan. 4) 1947.

2. Wohl, M. G., and Schneeberg, N. G.: Dietotherapy (Cardiovascular Disease), in Jolliffe, N.: Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, chap. 27.

3. Bills, C. E.; McDonald, T. C.; Niedermeier, W., and Schwartz, M. C.: Survey of the Sodium and Potassium Content of Foods and Waters by the Flame Photometer, *Fed. Proc.* 6:402 (Mar.) 1947.

4. Mayo Clinic Diet Manual, Philadelphia, W. B. Saunders Company, 1949, p. 113.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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Camels for keeps.

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(CYCLAMATE, ABBOTT)

the new heat-stable, non-caloric sweetener

WHAT IT IS: SUCARYL is a new non-caloric sweetening agent useful in the preparation of sugar-restricted diets for diabetic and obese patients. Its function is to supply the desired sweetness without adding carbohydrate, thereby making it easier for patients to adhere to a strict dietary regimen. SUCARYL is heat-stable, which permits its use in boiling, baking, canning and freezing processes without loss of sweetness. As a result, SUCARYL can be used in a great variety of foods. It has a sugar-like sweetness and leaves no bitter or metallic aftertaste in ordinary use.

HOW SUPPLIED: Now in calcium as well as sodium forms. Handy-to-carry SUCARYL Sodium tablets, eighth-gram, effervescent, grooved, in bottles of 100 and 1000; SUCARYL Sodium Sweetening Solution, liquid form convenient for household use, in 4-fluidounce bottles; and SUCARYL Calcium Sweetening Solution, newly developed non-sodium form for low-salt diets, in 4-fluidounce bottles.

RECOMMENDED USAGE: Recommended daily limit for adults, 12 tablets or about 1½ teaspoonfuls of solution. Since the tablets contain sodium bicarbonate as a disintegrator, somewhat lower sodium diets are possible with the sodium solution than with the tablets. Sodium content per tablet is 21.64 mg., while an equivalent amount of sodium solution contains 14.25 mg.

Patients on strict low-salt diets, however, should use the calcium solution. The calcium form has a lower bitter taste threshold, noticeable in some foods when the proportion reaches 0.5 percent, compared to about 0.8 percent for the sodium form. Both forms are equally good in ordinary use.

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even when the pollen count is high

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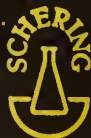
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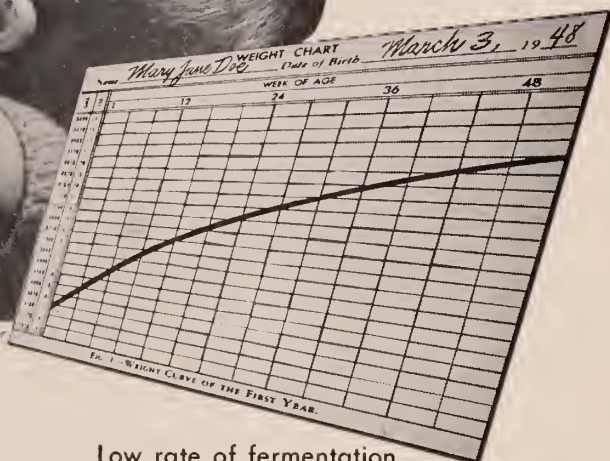
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Low incidence of digestive disturbances.

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1. Douglas, R. G.; Ball, T. L., and Davis, I. F.:
California Med. 73:463 (Dec.) 1950.

2. Pratt, P. T.: Nebraska State M. J. 35:294 (Sept.) 1950.

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Terramycin readily traverses the placental membrane and becomes available in the fetal circulation to combat or prevent fetal infection, said to be a frequent cause of premature labor or abortion. In both mother and fetus "very prompt response" with Terramycin treatment has been recorded in pneumococcic pneumonia complicating pregnancy.²



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2. The promptness of response to Terramycin

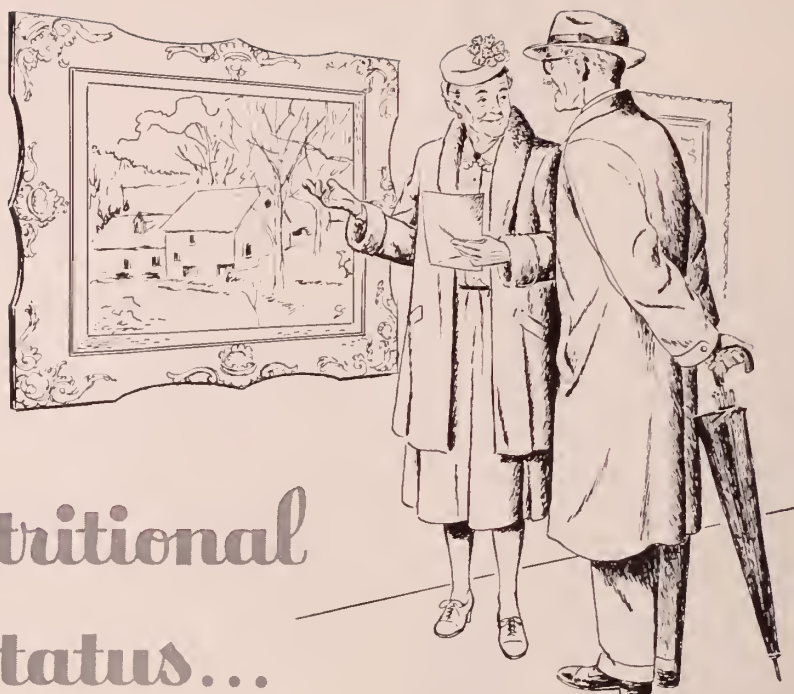
in acute and chronic infections involving a wide range of organs, systems and tissues.

Crystalline Terramycin Hydrochloride is available as:

CAPSULES, 250 mg., bottles of 16 and 100; 100 mg., bottles of 25 and 100; 50 mg., bottles of 25 and 100.

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Nutritional Status...

AN IMPORTANT FACTOR IN OLD AGE

A RECENT study¹ of the health and nutritional status of 200 elderly patients and their dietary habits revealed their food intake to be deficient in iron, calcium, protein, and, particularly, B complex vitamins. In many instances the lassitude and premature weakness of the elderly are due to such deficiencies.

Correction by increased intake of ordinarily eaten foods often proves difficult. The quantities that would have to be eaten frequently are more than the individual can consume comfortably.

Ovaltine in milk—a tasty, readily accepted and easily digested food supplement—offers a simple solution to this problem. Its wealth of biologically adequate protein, quickly utilizable carbohydrate, and needed vitamins and minerals, serves well in the aim of bringing nutrient intake to optimal levels.

The nutritional contribution of three servings of Ovaltine in milk (the recommended daily amount) is defined in the appended table.

1. Bortz, E. L.: Management of Elderly Patients, Postgraduate Med. 3:186 (Mar.) 1950.

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Three servings of Ovaltine, each made of
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PROTEIN	32 Gm.	VITAMIN A3000 I.U.
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CALCIUM112 Gm.	NIACIN	6.8 mg.
PHOSPHORUS094 Gm.	VITAMIN C	30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



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"In addition to the relief of hot flashes and other undesirable symptoms (of the climacteric), a feeling of well-being or tonic effect was frequently noted" after administration of "Premarin."

Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being."

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.



the clinicians' evidence

of the "plus" in

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Lilly

SINCE 1876



LILLY SINCE 1876

Mauve to golden

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President's Address

HERBERT E. WHITE, M.D.

ST. AUGUSTINE

To serve medicine today in official capacity is both a special privilege and a heavy responsibility. To the Florida Medical Association I am deeply grateful for conferring upon me its highest office, and during the two years of my service, first as president-elect and then as president, I trust I have proved in some measure worthy of the trust.

At the outset, I desire to pay tribute to one who for a quarter of a century has served the Association with intense fidelity and great efficiency as beloved official and guiding spirit. In January 1926 Dr. Stewart G. Thompson became Business Manager and since 1937 he has been Managing Director and Managing Editor of The Journal. As he rounds out slightly more than twenty-five years of service when he reaches his seventieth birthday on May 27 of this year, the plan for his retirement, adopted at the annual meeting in 1947, becomes effective. Fortunately, as specified in this plan, his services may now be retained on a special year to year basis, and he has been notified that the Board of Governors desires him to continue in his present capacity for the coming year. At the postconvention Board meeting on April 25 this important agreement will be consummated, and the Association is to be congratulated on having for the ensuing year the same able direction and wise counsel under which it has grown and prospered through the years.

During my tenure of office, the officers of the Association have won my warmest commendation and genuine appreciation. Their interest and cooperation have enabled me to carry on in behalf of the entire membership. In my opinion the average member does not appreciate fully the sacrifices in time, effort and money, made by those who serve officially. Such service entails devoting careful attention and much thought to policies and details of administration and requires leaving one's practice repeatedly to travel great distances almost always at one's own expense to attend meet-

ings. In no instance does the Association bear such expense, although many members are erroneously of the opinion that it does. The willingness to serve has been most gratifying.

In behalf not only of myself but also of the entire membership, I express appreciation to the Board of Governors and to the chairmen and other members of the respective committees for their valued contributions to the progress of the Association during the year now closing. By their very nature, the faithfully performed duties of some committees have been particularly arduous, notably those of two new committees, Advisory to Selective Service for Physicians and Allied Specialists and Emergency Medical Service, as well as those of the subcommittee on Review of Fee Schedules and such standing committees as Scientific Work, Public Relations, Legislation and Public Policy and others. Under the leadership of my predecessor in office, Dr. Walter C. Payne, the Grievance Committee he proposed last year has functioned well and is promoting good will between the laity and the profession both at the state and county levels.

As directed by action of the House of Delegates last year, I called a joint meeting of the Board of Governors, Members of the House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy, which was held in Ocala on Jan. 28, 1951. This was the first of the biennial conferences of these groups, to be held sixty days before the state legislature convenes, the purpose of which is to plan a definite legislative program and discuss bills that may be introduced during the legislative session. The attendance of 66 was excellent. In future, it would seem expedient for the Committee on Legislation and Public Policy to meet shortly before the general conference in order to discuss and clarify the issues to come before the larger group.

Voluntary Health Insurance

The rapid growth and development, and the promising potentialities, of all voluntary prepaid hospital and medical insurance plans are of interest and vital concern to every member of the Association. The nation's Blue Shield plans alone gained 5,000,000 new members during 1950 and paid out \$150,000,000 for surgical and medical services rendered to member patients. On Dec. 31, 1950, enrolment in the Florida Blue Shield plan was 203,783. This plan was started in September 1946. Individual doctors loaned \$20,672 for the purpose of getting it under way. In the four years and four months that have elapsed since that time, the plan has paid to the doctors of Florida \$2,394,017.06. Of this amount, \$1,324,988.16 was paid in 1950. These are impressive figures, but likewise sums that may well give pause for thought. Because of the close association of the Blue Shield and Blue Cross with the Association, it is my opinion that every member should be made keenly aware of certain practices by physicians throughout the state, as well as elsewhere in the nation, which are working to the detriment of both plans.

In a recent address entitled "Blue Cross Protects the People — Who Protects Blue Cross?" Dr. Paul R. Hawley, former chief executive officer of the Blue Cross and Blue Shield Commissions, reminded physicians and hospitals that Blue Cross and Blue Shield are wholly at their mercy. If the physician sends the patient to the hospital unnecessarily, orders services that are luxuries rather than necessities, and prolongs the period of hospitalization unduly, the expense will eventually price any plan out of its most important market and ultimately out of its very existence. Add such abuses to the already spiraling cost of hospitalization and the increasing utilization of the voluntary plan, and Blue Shield and Blue Cross will soon become too expensive for poor people. When that day comes, compulsory health insurance will quickly supplant the voluntary way, far more costly though it will inevitably be. And, curiously enough, as Dr. Hawley pointed out, those who will protest government medicine the loudest are those who are doing the most to hasten its arrival.

Health insurance appears to be the only insurance with no legal protection from abuses by the insured. There are laws against arson, and a law that protects an insurance company in an illegal death benefit claim. For the voluntary health insurance organization, however, the doctor alone is

the law; he is the only protection. His laxity jeopardizes the whole structure. He must keep in mind that Blue Shield and Blue Cross and the plans of commercial companies do not offer Utopia. They do not — indeed cannot — even lower the cost of medical care, as many, including physicians, erroneously think. They merely spread it. They are designed to pay what the patient cannot afford — not what he can afford to pay. For that reason diagnostic studies are excluded. To save a patient \$5 or \$10 that he is able to pay and should pay may cost the insurance company three or four times that amount, and all unnecessarily. Doubtless not a member of the Association questions the reasonableness of the \$50 deductible clause in his automobile insurance policy. But far too many members fail to realize that they themselves, the physicians, represent the \$50 deductible clause in the health insurance policy.

It should be obvious that it behooves physicians to protect an insurance company which they themselves fostered. Nevertheless, there is pressing need to educate physicians and also hospitals and the public to the realization that abuses of health insurance only raise the cost of this protection, that this cost can be kept low only by restricting its use to necessities, and that continued rising costs which the public cannot pay will bring Oscar Ewing's life dream daily nearer reality.

Freedom's Champion

Within the short period of two years, American medicine has emerged as a powerful champion of American freedom. It is no longer enough to be simply a good doctor, if one wants to remain a free doctor. Alert, aggressive citizenship, prepared to defend true Americanism, is also required. Many physicians have come to this realization; many more need to do so. The importance of physicians as individual citizens interesting themselves in state and national politics cannot be overemphasized.

With pride, I congratulate the members of the Association upon the way in which they have exercised their individual rights as good citizens during the last year, especially at the primary of May 2, 1950. With pleasure, I present a message from Mr. Clem Whitaker, Director of the National Education Campaign of the American Medical Association, as follows: "There is no question that the example set by Florida doctors, early in 1950, inspired thousands of other members of the profes-

sion in other States to go and do likewise, and the results certainly contributed to the economic health and well-being of the Nation." In the letter, dated Feb. 7, 1951, from which this quotation is taken, Mr. Whitaker urged me to stress the great need for continued vigilance and militant action on all fronts, for "we have won some battles, but not the war—and we are in great danger of suffering from overconfidence." The accomplishments of 1950 must indeed be safeguarded and augmented during 1951 and 1952.

The Woman's Auxiliary

The increased activities and excellent work accomplished by the Woman's Auxiliary merit the highest praise. The untiring efforts of its members in battling socialized medicine and in promoting improved public relations have been an invaluable contribution to Florida medicine. The Association salutes the doctors' wives and looks to them to further the cause of medicine in the future as zealously and as successfully as they have in the past. I should like to urge all members of the Association to encourage their wives to join the Auxiliary. In counties where there is no component auxiliary, the wives may be members at large.

American Medical Education Foundation

That the medical profession must ever remain alert to the inroads of federal interference is illustrated by the present disposition on the part of the administration in Washington to foist upon the public its socialistic proposals as "emergency" legislation. The effort to secure federal subsidization of medical schools, which, if successful, would inevitably result in federal control of the schools, is a glaring example.

If the medical schools are to remain free and unfettered by the snare of governmental subsidy, private enterprise must finance them. Rising costs, inflation, fewer large individual benefactions and reduced income from endowments have placed these schools in need of immediate assistance, and failure to provide it would be the delight of Ewingism. Accordingly, the American Medical Association has appropriated \$500,000 as the nucleus of a fund to be raised to meet this need, and the American Medical Education Foundation, a not-for-profit corporation, has been set up to receive and distribute contributions to the fund. All expenses of the Foundation will be absorbed by the American Medical Association so that every dollar

contributed will go to the medical schools, and will probably be tax-deductible. No strings are attached to the aid granted from this fund to the seventy-nine approved medical schools throughout the nation; each school is free to determine how it best can use its share to further the basic training of its students. Also, a physician who so desires may earmark his money for his alma mater or any other of these schools.

All American physicians are urged to contribute individually to this fund and to take the lead in obtaining contributions from other sources. Already there has been heartening response in contributions, notably \$100,000 from the California Medical Association, and in pledges and expressions of approval and encouragement from many sources in and out of medicine. This constructive action on the part of the medical profession is expected to stimulate other professions, industries, businesses, labor groups and private donors to contribute individually. Every American who prefers individual initiative and private enterprise to governmental domination and control has a stake in this project.

The key to success in this fund-raising campaign rests, however, with the state and county medical societies. Stimulation from these levels is now reaching out to the physicians in every city, town and community. As have other state associations, this Association has a committee for this purpose, and every county society is to have one to promote this worthy cause through proper channels. All will wish to contribute and all must realize that substantial amounts on a yearly basis, not mere token contributions, are essential. This support is necessary to assure an adequate future supply of physicians through American methods which will preserve the standards and freedom of medical education.

National Defense

The physician has no desire to be glamorized, and properly so, but he does need to be ever aware of and alert to his key position in the nation's life. He has been thrust into the vanguard in the fight against socialization and has acquitted himself so far with rare distinction. He is accepting the challenge to shoulder broader responsibilities of citizenship in local, state and national politics. He is coming to realize how completely the whole fabric of the country's health pattern and the ultimate success or failure of that bulwark against social-

ized medicine, the voluntary health insurance plans, rest upon his integrity, judgment and common sense. He is being called upon to lead in the movement to save medical education from the scheming bureaucrats who would pervert it into an instrument for the advancement of state medicine.

And now, in the present emergency, he is confronted with a key role in both civilian and military defense. His obligation to the military services he is discharging with great credit to the profession, as always. But how well prepared is he to meet the challenge of civilian defense? Too much depends upon an adequate and early state of medical preparedness for him to be other than wholly realistic about the fact that the heart of civilian defense lies in medicine and in the physicians who implement it. Florida with more than 2,000 miles of coast line and numerous critical target areas is highly vulnerable to attack. The Association through able representatives is cooperating in the state's civilian defense program, and its members will not be found wanting in this new responsibility which devolves upon them.

Recommendations

Among the members of the Association there are a few advanced in years or suffering physical disability who of necessity continue to practice a little, but find the payment of dues a financial hardship. One of this number is a nonagenarian. I heartily recommend that the House of Delegates pass the recommendation to amend the By-Laws so that in such instances, as determined by the county medical society and deemed advisable by the Board of Governors, the dues may be waived.

Prior to each biennial conference of the Board of Governors, Members of the House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy, ordered to convene sixty days prior to the meeting of the state legislature to plan a legislative program, I recommend that the Committee on Legislation and Public Policy hold a preparatory meeting, preferably two weeks in advance, to clarify the issues, arrange the agenda, agree upon the bills to be presented and have them properly drawn. I further recommend that a copy of these bills be sent promptly to each county medical society with instructions to have its committee on legislation and public policy contact the senator and representatives from its district, familiarize them with these measures and endeavor to obtain from them an expression of their attitude toward the proposed bills before the legislature opens.

I recommend that the membership to a man make every effort to protect its own Blue Shield and Blue Cross and other worthy voluntary health insurance plans, and thereby the public interest, by (1) controlling admission of patients to the hospital and explaining the reason to the patient; (2) cooperating with each other by not admitting a patient because he has insurance when a colleague has refused to do so; (3) not abusing admission of patients for tonsillectomy and adenoidectomy; (4) not ordering unnecessary laboratory work, including tissue examinations; (5) not requesting electrocardiograms and basal metabolism tests when inconsistent with the diagnosis; (6) not ordering diathermy or physiotherapy unless necessary; and (7) discontinuing special drugs as soon as the patient's condition warrants.

To each and every member as an individual citizen I recommend the exercise of his inalienable rights of citizenship in the interest of "life, liberty and the pursuit of happiness," the American way of life; I urge him to become more politically minded, in keeping with his stellar role in protecting the health and welfare of the nation.

Finally, in the interest of preparedness in these uneasy times, I recommend that every member, mindful that there is no leisurely approach in catastrophic situations, acquaint himself fully with such "facts of life" as are available about atom bomb attacks and prepare himself to cope with disaster in the masterful way expected of his high calling.

Objectives for 1951

Through careful planning and the enthusiastic efforts of its 2,100 members, the largest number in its history, the activities of the Association have increased greatly during the year. The difference between this gratifying progress and actual retrenchment has been the wise action of the House of Delegates last year in increasing the membership dues \$15. Without this increase, the Association would have lost the prestige in rank it has gained in comparison with other state medical societies. There are this year 17 state medical associations with assessed membership dues of \$40 or over, whereas last year there were but 6. Only 3 state medical societies had membership dues of \$50 in 1950, but now, in 1951, there are 7 with membership dues of \$50, 1 with dues of \$55 and 1 with dues of \$75. By continuing to utilize the statesmanlike leadership and diversified talents within its membership, the Association will remain

in top-ranking position among state medical associations.

The additional revenue derived from the timely increase in the membership dues has made it possible to carry on an enlarged program in keeping with the broadened scope of medicine's activities both nationally and within the state. Without the increase in funds, Florida medicine could not have attained and maintained the high place among the states it has won for itself during the year in public relations and education campaign projects. Cooperation with the government in coordinating its selective service program would have been greatly handicapped. Also, without more money it would have been impossible from an administrative standpoint to perform the duties necessary to assist appropriately the American Medical Association in the collection of its dues and in such important projects as its national advertising and American Medical Education Foundation campaigns. The wisdom of last year's forward step in providing funds through dues has been proved over and over again during the year, and it is not pleasant to contemplate how impotent the Association would be to meet the demands of this critical hour for medicine and the nation without this provision.

American medicine is today in the strongest public position it has ever held. Every right-thinking physician should be profoundly thankful that the majority of the people of this country, when given the facts on the issue of socialized medicine, spoke out sharply against the abridgment of individual freedom—in the election returns, in the widespread public support of the American Medical Association's advertising program, and in the steadily growing number of organizations endorsing medicine's position. Nevertheless, the profession cannot afford to rest on its laurels. Gains must be consolidated and solidified.

While in most respects Ewingism has declined to the status of a first class political liability, the ranks of labor are its one remaining bastion. Labor leaders have persisted stubbornly in their espousal of socialized medicine. In local union leadership and in the rank and file of labor, however, there is strong support for American medicine. According to one survey, nearly half of the country's wage earners are against socialized medicine and only one fourth favor it. A primary 1951 objective is to bring this support out into the open. Working from the grass roots up should effect a strong and timely alignment.

The social planners are zealously at work bringing their influence to bear on other groups also, such as the Parent-Teacher Association, the League of Women Voters, the American Association of University Women and the nurses' associations. The grass roots approach here, too, offers the most promising results and affords physicians and physicians' wives everywhere a broad opportunity for constructive work in combating socialistic propaganda.

There are indications that the movement to socialize the legal profession is spreading to this country from Great Britain, where it is already under way. The legal profession has proved a vigorous ally of the medical profession on the issue of medical freedom, and that relationship should now be cemented even closer. Physicians should lose no opportunity to enlist the aid of their lawyer friends in acquainting the people with the threat of regimented serfdom which menaces them.

It is the task of all to keep the issue clearly drawn. Millions of Americans do not yet realize that the issue is not merely socialized medicine, but actually State Socialism which threatens their country. They must come to understand that the whole American way of life is in jeopardy.

Now is the time to "accentuate the positive." One way of doing so is to lend wholehearted support to extension and improvement of the medical and hospital care plans and the indemnity plans of the accident and health insurance companies. Coverage should be expanded until all who need medicine on a budget basis can secure it at a price they can afford. The growing demand for individual enrolment plans must be met, and improved types of coverage, such as greater protection against prolonged, catastrophic illness, must be provided.

Within two short years, American medicine has dealt a mortal blow to the nefarious schemes of the Ewing clique. The call of 1951 is to fresh enlistment in the battle to the death to preserve, defend and promote the best traditions of this nation. Without question, the medical profession will continue its front line advance during this first year of the second half of a fateful century and will carry on valiantly and vigilantly until the American way of life is made permanently secure for all the people.

PROCEEDINGS

Seventy-Seventh Annual Meeting

of the

FLORIDA MEDICAL ASSOCIATION
HELD AT HOLLYWOOD
APRIL 23, 24, and 25, 1951

GENERAL SESSIONS

First General Session

The Seventy-Seventh Annual Meeting of the Florida Medical Association was called to order at 9:30 a.m., Monday, April 23, in The Sun Room of the Hollywood Beach Hotel, Hollywood, by President Herbert E. White.

Invocation was pronounced by The Reverend Robert E. Fry, D.D., Pastor, Hollywood Presbyterian Church.

Dr. M. Austin Lovejoy, president of the Broward County Medical Society, gave the address of welcome.

President White introduced Mrs. C. Robert DeArmas, president-elect of the Woman's Auxiliary to the Florida Medical Association.

Mrs. DeArmas introduced Mrs. Arthur Herold, President of the Auxiliary to the American Medical Association who spoke briefly.

Mrs. Herold: "I am happy to be here this morning and I know you have a busy session. I come to ask you to give your assistance and cooperation to the Woman's Auxiliary to the Florida Medical Association and the American Medical Association. The women are trying to work for you, but they need your support and cooperation. There is magic in the words when a woman says, 'My husband is 100% for me to do my part.'

"Give us your messages to the people and we will bring the people's messages back to you. We feel that we can be your best public relations ambassadors.

"We need more women. We have an organization of about 60,000 and the men have about 180,000. I solicit your help, your assistance and your cooperation and thank you for letting me speak to you this morning."

There being no further business, the meeting adjourned at 9:40 a.m.

Second General Session

The Second General Session of the Florida Medical Association meeting convened at 2:20 p.m., Monday, April 23, in The Sun Room of the Hollywood Beach Hotel; President White in the Chair.

Dr. White: "I know every member of the Association would like to know about our financial condition and what happens with our dues. Today, we have the one to tell us, Dr. Robert B. McIver."

The report of the secretary-treasurer and managing director was read by Dr. Robert B. McIver, as follows:

**Report of Secretary-Treasurer
Dr. Robert B. McIver
and Managing Director
Dr. Stewart G. Thompson**

Mr. Chairman, Members of the Association and Guests:

The membership as of March 20 reached an all-time high with a total of 2,173. A year ago the total was 2,032. There is, therefore, an increase of 141 members during the twelve-month period. The following members are not required to pay state dues: life, 103; honorary, 61; and secretaries of county medical societies, 35, making a total of 199. (There are 36 county medical society secretaries but 1 is also a life member.)

The six county medical societies ranking highest in total membership are Dade 558, Duval 244, Pinellas 182, Hillsborough 160, Orange 145, Palm Beach 102.

Receipts for the fiscal year ending March 20 totaled \$102,193.19 and disbursements were \$83,257.39. The balance of \$18,935.80 must not all be considered as gain for approximately 75% of the members paid their dues for the calendar year 1951, before March 20. Part of the money received in advance from dues will be used for operating expenses during the following nine months of this year. The dues are collected on a calendar year basis which makes the fiscal year figure misleading.

In April of 1950, we reported that the backlog carried in the Association's checking account was practically wiped out. In the same year the December balance was so low that it was feared the monthly checks could not be issued. We are glad to be able to report that the dilemma is passed and with the increase of annual dues a similar situation should not be anticipated in the future.

The Association's activities during the past year have increased through careful planning and the enthusiastic efforts of its capable members.

The wise action of last year's House of Delegates to increase the membership dues \$15.00 was the difference between retrenchment and progress. It is gratifying to realize that without this increase of membership dues, the Association would have also lost the prestige in rank as compared to other state medical societies.

This year 17 state medical societies assessed membership dues of \$40.00 or over as compared with only 6 in 1950. Last year 3 state medical associations had membership dues of \$50.00 and in 1951 there were 7 with membership dues of \$50.00, one with \$55.00 and one with \$75.00.

If the talents and leadership within the Association's membership are utilized, it will continue to rank among the top state medical associations.

ANNUAL DUES — CERTAIN STATE
MEDICAL ASSOCIATIONS — 1951

Nevada	\$75	Wisconsin	\$50
Idaho	55	Michigan	45
Arizona	50	Oklahoma	42
Colorado	50	California	40
Iowa	50	Dist. of Col.	40
Montana	50	N. Hampshire	40
N. Dakota	50	N. Carolina	40
S. Dakota	50	Rhode Island	40
FLORIDA	\$40		

Bureau of Public Relations

A review of criticisms and suggestions of Association members with reference to the Public Relations Program resulted in the compilation and publication in July 1950, of an 8-point, concrete Public Relations Program to serve as a guide for public relations activities. The Bureau has worked principally with the Association's Committees on Public Relations, Legislation and Public Policy, State Education Campaign, and officers of the county medical societies by assisting and carrying out details as requested.

Public Relations activities have been continued by supplying radio stations with electrical transcriptions; supplying newspapers with weekly health topics and news items of interest; distributing Education Campaign material; and processing Briefs to disseminate national, state and local information of interest to the association membership.

Arrangements were made for 100 bookings in commercial theatres of Florida on "To Your Health," a 10-minute sound motion picture which bring the case against socialized medicine before the public.

The AAPS Essay Contest entitled "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care" was sponsored again this year and every junior and senior high school in the state was supplied with a packaged library kit. Awards of \$100, \$50 and \$25 were made available for contestants placing first, second and third. Winners this year were: First, Pierce Johnson, Fernandina High School; second, Ann Peters, Gainesville High School; and third, Barbara Bunch, Haines City High School. Dr. J. Maxey Dell, Jr., of Gainesville, served as chairman of a board of judges selected by the President. He was assisted by Dr. C. E. Mounts and Dr. D. E. Baughan of the Department of English, University of Florida.

Field work has taken a great deal of the time of the Supervisor of the Bureau, Mr. Wm. Harold Parham. He has attended the National Conference on Voluntary Health Insurance sponsored by the AMA Council on Medical Service; the AMA Third Annual Public Relations Conference on county medical society programs; the AMA Third Annual National Education Campaign Conference; AMA Regional Conference on Voluntary Health Insurance; AMA Regional Conference on Legislation; FMA District Medical Meetings; Dade County Medical Association Press and Radio Conference; Annual Conference of the Florida Press Association; and meetings of committees of the Association which related to public relations activities. He has contacted newspapers, radio stations, civic and allied organizations, legislators, and influential individuals in an effort to bring about a closer relationship and to coordinate public relations programs.

Your Bureau Supervisor is also a lieutenant in the Army Reserves. On March 10, 1951 he left his Association post for active duty in Washington, D. C. He is currently assigned to Fort Meade, Maryland, as a medical public relations officer. Lt. Parham's absence has necessitated some reorganization and shifting of work load. The Bureau is still available, as in the past, for information and assistance at all times.

The Journal

The number of Journals printed during the past year totaled 29,135 as compared with 27,652 for the previous year, an increase of 1,483. The cost of printing The Journal was advanced 10 per cent in February. Paper stock and other essentials are costing more with rising prices.

Medical Directory

One free copy of the 1951 Florida Medical Directory was mailed to each member of the Association. Additional copies may be purchased at \$2.00 each.

Association's Headquarters

Your headquarters offices are located at 128 E. Forsyth Street, Jacksonville. On the regular staff, there are 9 employees. We wish especially to mention Mr. Ernest R. Gibson, Assistant Managing Director, and Mrs. Zoe Pack, Chief Clerk.

With the increase of membership, the Association program of activities has broadened to such an extent that the office personnel is loaded with a daily grind to turn out the volume of work required.

Your administrative office is required to collect from the secretaries of the county medical societies the AMA dues and transmit them to the Chicago office as well as keep a file record on each individual member. These AMA dues are not entered in the Association's official books or deposited in a local bank. The correspondence required to adjust the individual member's AMA dues consumes a great deal of the office personnel's time. The expanded program of the AMA floods down to this office with inquiries, literature, circular letters, questionnaires and requests for state participation which is in addition to the enlarged program of your Association.

Finances

The financial statements appearing at the end of this report will be published in The Journal for the benefit of members who wish to study the details.

The books and records of the Association are open to the members and we will be glad to answer inquiries of any nature upon request. The books have been audited by Goodrich & Varnedoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Respectfully submitted,
Robert B. McIver, *Secretary-Treasurer*
Stewart G. Thompson, *Managing Director*

Exhibit "D"

Medical Postgraduate Course Committee-IX

March 21, 1950 through March 20, 1951

Receipts

Cash as per Last Audit	\$ 646.58
Registration Fees, Etc. — 1950 Postgraduate Course	2,175.00
TO BE ACCOUNTED FOR	\$2,821.58

Disbursements

Dr. T. Z. Cason, Chairman — Expenses	1,800.00
BALANCE IN BANK — March 20, 1951	\$1,021.58

Exhibit "B"

Statement of Receipts and Disbursements

March 21, 1950 through March 20, 1951

Balances — March 21, 1950

Florida National Bank— Checking A/c	\$34,888.42
Atlantic National Bank —Savings A/c	9.17
Barnett National Bank— Savings A/c	1,883.35
	<u>\$ 36,780.94</u>

Receipts

Back Dues	\$16,325.00
Current Dues	56,440.00
Entrance Fees	2,200.00
	<u>\$74,965.00</u>

Interest on Savings Ac- counts	18.87
Miscellaneous Income	483.38
Advertising—Journal	\$13,949.69
" —Directory	815.00
	<u>14,764.69</u>

Journal Subscription & Sales	296.25
Directory Sales	382.00
Technical Exhibits	9,175.00
Convention Smoker	2,108.00
	<u></u>

TOTAL RECEIPTS 102,193.19

TO BE ACCOUNTED FOR \$138,974.13

Disbursements

Administrative:	
Postage and Express	\$ 1,080.66
Office Supplies	923.35
Telephone and Tele- graph	1,204.71
Travel Expense—Mng. Dir. and Asst.	469.66
Delegates to A.M.A. (2) Transportation	724.37
Office Rent	2,400.00
Towel Service	16.50
Bank Exchange	9.62
Custody of Bonds	50.00
Treasurer's Bond	37.50
Employer's Liability Insurance	30.60
Maintenance — Office Equipment	151.00
Rental—Safety Deposit Box	15.00
Blue Cross and Blue Shield (Assn. Em- ployees)	182.40
Federal Tax	495.40
State Sales Tax	538.50
Unemployment Com- pensation Fund	428.77
Federal Excise Tax	47.68
Furniture and Fixtures	1,297.20
Books, Pamphlets, Etc.	298.50
Payrolls	24,180.23
Contractor Fees	1,575.32
Retirement Trust Fund	3,600.00
Journal Printing and Paper	12,358.98

Dray	56.65
Printing and Engrav- ing	578.98
Directory Printing, etc.	1,311.20
Convention Expense	2,982.55
Miscellaneous Commit- tee Expense	192.77
Convention	
Smoker, Etc.	1,980.04
Reprints — Non-Mem- ber	46.54
Rental — Post Office Box	8.00
Incidental	3.50
	<u></u>

TOTAL ADMINISTRATIVE \$59,276.18

Bureau of Public Relations:

Postage and Express	\$ 790.80
Office Supplies	474.24
Payrolls	10,437.50
Contractor Fees	139.88
Insurance—Blue Cross and Blue Shield	50.40
Telephone and Tele- graph	604.81
Travel Expense—Su- pervisor	1,234.18
Federal Tax	187.87
State Sales Tax	91.38
Unemployment Com- pensation Fund	228.87
Federal Excise Tax	25.46
Office Rent	1,272.00
Furniture, Fixtures and Equipment	882.16
Books, Pamphlets, Etc.	790.16
Printing and Engraving	927.65
Maintenance — Office Equipment	28.13
Legislation, Public Pol- icy	3,000.00
State Education Cam- paign	2,628.95
Insurance on Equip- ment	62.57
Rental — Post Office Box	8.00
Incidental	1.03
Chamber of Commerce Membership	100.00
Press Association Mem- bership	15.00
	<u></u>

TOTAL BUREAU OF PUBLIC RELATIONS 23,981.21

TOTAL DISBURSEMENTS 83,257.39

Balance—March 20, 1951 \$ 55,716.74

Balance Comprised of:

Florida National Bank Checking A/c	\$53,805.35
Atlantic National Bank Savings A/c	9.17
Barnett National Bank Savings A/c	1,902.22
	<u>\$ 55,716.74</u>

Exhibit "A"
Statement of Assets and Liabilities
March 20, 1951

<i>Assets</i>			
Florida National Bank —			
Checking A/c	\$ 53,805.35		
Atlantic National Bank			
— Savings A/c	9.17		
Barnett National Bank			
— Savings A/c	1,902.22	\$ 55,716.74	
Accounts Receivable:			
General Fund	\$ 22,520.00		
Journal Fund	1,228.92		
Non-Member	46.54	23,795.46	
Inventory-Stationery		1,990.66	
Retirement Trust Fund			
— Atlantic National			
Bank		15,829.65	
Investments:			
Treasury and Savings			
Bonds		29,840.50	

<i>Trust Fund:</i>			
Barnett National Bank			
— Checking A/c			1,021.58
Furniture & Fixtures:			
General Fund	\$6,543.39		
Less Depreciation			
Reserve	3,129.82	\$ 3,413.57	
Bureau of Public			
Relations Fund	\$3,503.94		
Less Depreciation			
Reserve	536.99	2,966.95	6,380.52
TOTAL ASSETS			\$134,575.11
<i>Liabilities</i>			
Reserve — Postgraduate			
Course Committee	\$ 1,021.58		
Net Worth	133,553.53		
TOTAL LIABILITIES			
AND NET WORTH			\$134,575.11

Exhibit "E"
Dues and Entrance Fees Collected March 21, 1950 Through March 20, 1951

Name of Society	Total Members	No. Paid Members	No. In Arrears	1951 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	47	44	3	1,520.00	125.00	60.00
Bay	22	17	5	600.00	125.00	70.00
Brevard	19	18	1	600.00	25.00	20.00
Broward	80	63	17	2,240.00	450.00	100.00
Columbia	17	12	5	440.00	25.00	10.00
Dade	558	347	211	12,680.00	5,550.00	480.00
Desoto-Hardee-Highlands-Glades	25	22	3	720.00	75.00	10.00
Duval	244	169	75	5,480.00	2,525.00	160.00
Escambia	73	10	63	160.00	1,675.00	120.00
Franklin-Gulf	6	5	1	160.00	125.00	
Hillsborough	160	124	36	4,280.00	725.00	120.00
Indian River	7	7	0	240.00		
Jackson	17	12	5	360.00	125.00	10.00
Lake	25	21	4	760.00	75.00	40.00
Lee-Charlotte-Collier-Hendry	25	23	2	840.00	50.00	20.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	51	47	4	1,680.00	150.00	60.00
Madison	3	3	0	80.00	50.00	
Manatee	21	13	8	440.00	400.00	20.00
Marion	28	23	5	720.00	50.00	10.00
Monroe	10	8	2	240.00		
Nassau	9	9	0	240.00		
Orange	145	123	22	4,680.00	825.00	160.00
Palm Beach	102	82	20	3,160.00	675.00	70.00
Pasco-Hernando-Citrus	13	11	2	320.00	25.00	10.00
Pinellas	182	168	14	6,000.00	200.00	210.00
Polk	85	65	20	2,320.00	650.00	50.00
Putnam	10	9	1	320.00	25.00	10.00
St. Johns	16	14	2	480.00		30.00
St. Lucie-Okeechobee-Martin	17	12	5	440.00	175.00	40.00
Sarasota	42	38	4	1,360.00	850.00	170.00
Seminole	13	12	1	440.00	25.00	10.00
Suwannee	8	6	2	200.00	25.00	10.00
Taylor	3	1	2			
Volusia	69	57	12	1,960.00	500.00	110.00
Walton-Okaloosa	16	14	2	440.00	25.00	10.00
Washington-Holmes	5	1	4			
Totals	2,173	1,610	563	56,440.00	16,325.00	2,200.00
Dues Not Payable				16,325.00	Back Dues Collected	
Co. Soc. Secys.	35					
Life	103			72,765.00	Total Dues Collected	
Honorary	61	199		2,200.00	Entrance Fees Collected	
1951 Dues Paid Jan. to March 21		1,411		74,965.00	Dues and Entrance Fees	

Exhibit "C"
Retirement Trust Fund
Analysis of Changes

March 21, 1950 through March 20, 1951

BALANCE ON HAND— March 21, 1950				\$11,972.84
ADDITIONS				
Transfers from General Fund		\$3,600.00		
Income:				
Gross Interest on Bonds		\$318.75		
Less:				
Accrued Interest Paid on Purchases	\$37.15			
Income Tax Paid	24.79	61.94	256.81	
NET ADDITIONS				3,856.81
BALANCE ON HAND— March 20, 1951				\$15,829.65

April 12, 1951

Dr. Robert B. McIver
Secretary-Treasurer
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Mr. Stewart G. Thompson, Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the Association, maintained in his office, for the period March 21, 1950 to and including March 20, 1951, and submit herewith our report consisting of:

- Exhibit "A"—Statement of Assets and Liabilities as at March 20, 1951
- Exhibit "B"—Statement of Receipts and Disbursements for period March 21, 1950 to March 20, 1951
- Exhibit "C"—Analysis of Changes in Retirement Trust Fund
- Exhibit "D"—Statement of Receipts and Disbursements—Medical Postgraduate Course Committee

The recorded receipts were regularly deposited to the credit of the Association, and the disbursements appeared to be for proper purposes.

Bank balances were independently verified and we inspected war bonds of a maturity value of \$40,325.00.

Due to inaccessibility of records of the various County Societies no attempt was made to verify remittances for dues, or the accounts receivable of the Association.

Yours very truly,
(Signed) Goodrich & Varnedoe
Certified Public Accountants

CHG/d

Dr. White: "Next, the report of the editor of The Journal, Dr. Shaler Richardson."

The following report of the editor of The Journal was read by Dr. Richardson:

Report of Editor of The Journal
Dr. Shaler Richardson

The Journal will close thirty-seven years of progress with the June issue. Your editor and his staff are pardonably proud of the favorable comparison of your Journal with others in the field. We are equally appreciative that only through the generous sharing of knowledge and experiences on the part of the members has this continuous advancement been possible.

Twenty-six years ago you elected me editor for the first time. It has been an honor and pleasure to serve continuously in that capacity with the exception of two years as president-elect during World War II and one year as president. It has been a constant challenge to keep pace with the tremendous advancement in medical science during the past quarter-century.

Circulation continues to mount with the increase in membership of the Association and the surprising popularity of The Journal without the state. Current figures show a total circulation of 2,500, roughly a 10 per cent increase over one year ago. Of these more than 2,100 go to active members, the remainder being distributed among individual subscribers, advertisers and exchanges.

Increased circulation automatically adds to the publishing costs, which are already at an all time high and steadily increasing. Printing and paper stock, which constitute major expense items, have risen appreciably during the past year. A flat 10 per cent increase was tacked on by the printer in February. The expenses mentioned do not include postage, office rent, equipment, salaries of staff personnel, etc. Revenue from advertising and subscriptions have remained fairly constant.

Forty-eight scientific papers have been published during the past fiscal year, of which 39 were by members. Fifteen of the papers were read before the scientific assemblies of the 1950 annual meeting at Hollywood. These were given just priority in the publication schedule. Other articles published were selected from outstanding papers submitted by members.

Abstracts serve as a valuable guide to members seeking information on scientific subjects. During the past year 43 abstracts of articles published by our members in other journals formed a significant part of The Journal's service to its members. The staff is constantly scanning other journals for articles published by our members. However, there is no assurance but that some valuable paper may have been missed. You can add greatly to the value of this section by sending us reprints of your articles published in out-of-state medical journals.

Second only to the caliber of scientific articles in the evaluation of a medical journal are its editorial policies. That our editorial and commentary section measures up is due largely to valuable assistance from the assistant and associate editors. A sincere attempt is made to keep these pages sufficiently diversified so that all members will find something of interest. You will find them timely and informational, and you may even find some of them disturbing. Naturally the scientific problems come first, and you have witnessed many fine editorials from the able pen of the assistant editor, Dr. Webster Merritt. You will also find that the intricacies of modern life have made necessary the consideration of problems in medical economics, public relations and other fields.

News items and county society notes are always read with interest. These will continue to be an important part of The Journal, but they could be more valuable and informative with greater contributions from members. The staff searches diligently for news, but many items of interest never come to its attention. The county societies which publish bulletins provide us with a constant source of information about their county activities and the activities of their members. A few of the societies have elected reporters whose duty it is to see that news items and society notes reach The Journal regularly. For the societies who have neither bulletin nor reporter, our only source of information is through a newspaper clipping service.

Among other features of note which are well worth your perusal are those on Your Blue Shield, State Board of Health and Books Received. For your convenience The Journal carries a list of Association officers and committee members, a schedule of meetings of certain medical organizations and a tabulation of the county societies together with their presidents, secretaries, meeting dates and current membership. These should be almost invaluable to the members, particularly to Association officers, committeemen and county society officials. Yet it is indeed surprising at the number of inquiries coming into the headquarters office for which the answers may be obtained readily from The Journal on the doctor's desk.

I particularly desire to take this opportunity to express appreciation to Dr. Webster Merritt, assistant editor, and to the associate editors, Drs. Louis M. Orr, II, Franz H. Stewart, James R. Boulware, Jr., Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar and Walter C. Payne. The assistance of Drs. Chas. J. Collins and James N. Patterson, the other members of the Committee on Publication, have been invaluable. One or both of these members read and edited the scientific articles published in The Journal before they were finally referred to me. This takes time and effort which should merit the special appreciation of the membership.

Without the aid of the abstract chairman, Dr. Kenneth A. Morris and his able helper, Dr. Walter C. Jones, that section of The Journal would function much less smoothly.

No journal is better than its managing editor. At this time I want to express sincerest appreciation to Dr. Stewart Thompson for a quarter-century of faithful and able service to The Journal. Mr. Ernest Gibson, journal technician, has also rendered valuable assistance during the last year and a half. Special mention goes to Mrs. Edith B. Hill, manuscript editor, who carefully edits all scientific papers before they are sent to the printer. In addition she assists on editorials and commentaries.

I want to emphasize that this is your journal. It can be only as big and as great as you are willing to work to make it. Your journal is a fairly accurate reflection of the medical progress in the state and thus it mirrors the medical profession and each individual member who makes up this Association.

Respectfully submitted,
Shaler Richardson, *Editor*

Dr. White: "At this time I pass the gavel over to Dr. Richard A. Mills, first vice-president."

Dr. Mills: "Our president, Herbert White, will now deliver his annual address."

At the end of President White's address, the membership stood in appreciation.

Dr. Mills: "Thank you, Dr. White, for that excellent address and also for your hard work during the year."

Dr. White resumed the Chair.

Dr. White: "At this time, we have the pleasure of recognizing delegates from other state medical associations. In the past, many members will recall, we have had the pleasure of seeing members from Georgia and Alabama, and I would now like to recognize delegates from other state associations."

Dr. Rudolph Bell of Thomasville was recognized and came to the rostrum.

Dr. Bell: "I would like to say that the Medical Association of Georgia has just concluded its one hundred and second annual meeting. I come to

you as a representative from that Association to wish for you, although a much younger organization and perhaps a much wealthier one, a most successful meeting. I am very happy to be here."

There being no further business or announcements, the second general session adjourned at 3:15 p. m.

Third General Session

The Third General Session of the Florida Medical Association meeting convened at 11:38 a.m., Tuesday, April 24, 1951 in The Sun Room of the Hollywood Beach Hotel, Hollywood; President White in the Chair.

The meeting was called to order.

The guest speaker, Dr. Lon Grove, Associate Professor of Clinical Surgery, Emory University School of Medicine, Atlanta, was introduced by President White.

DR. WHITE: Members of the Florida Medical Association, Members of the Auxiliary, and Guests:

Seldom does one have the opportunity of presenting a guest speaker that one has known from medical school days. The man whom I have the honor and privilege of presenting to you today I have followed around the hospital wards of Emory University School of Medicine, listened to his discussions and diagnoses, and watched his surgical skill in the operating rooms. I have followed his advice and counsel for many years, admiring him greatly not only as a surgeon, but as an outstanding citizen of his community. At the close of World War I, in October 1918, he was decorated by the French Government for distinguished service to France.

I have felt particularly close to our distinguished guest, for it was due to his diagnostic skill and ability that my mother is alive today. She is now approaching 80 years of age, and six years ago, when she was suffering with a serious abdominal malignancy, his skill and keen surgical judgment saved her life.

This eminent surgeon has for many years been a member of the faculty of Emory University School of Medicine. As Associate Professor of Clinical Surgery, he has given much of his time and ability, for many years, to teaching young doctors. He has been keenly interested in promoting good fellowship and surgical teaching by his membership and association in the outstanding surgical societies of this country. He was one of the founders of the American Board of Surgery, and has been a frequent contributor to surgical publications. He has accredited himself in his chosen specialty of abdominal surgery.

It is with a distinct feeling of pride and pleasure that I present to you our guest speaker, Doctor Lon Grove, whose address today is, "Surgery of the Biliary Tract: A Personal Experience with Eight Hundred and Fifty Consecutive Cases in Private Practice."

Doctor Grove.

Address: "Surgery of the Biliary Tract, a Personal Experience with Eight Hundred and Fifty Consecutive Cases in Private Practice" by Dr. Grove.

President White thanked Dr. Grove for his outstanding presentation.

There being no further business or announcements, the Third General Session adjourned at 12:50 p.m.

HOUSE OF DELEGATES

First House of Delegates

The House of Delegates convened at 9:45 a.m., Tuesday, April 24, 1951 in The Sun Room of the Hollywood Beach Hotel, Hollywood, with Dr. Herbert E. White, President, in the Chair.

Dr. Louis M. Orr, II, chairman of the Credentials Committee, was recognized and reported 105 delegates whose credentials were in order.

The Chair stated that a quorum was present.

Dr. Ralph Herz moved that the delegates be seated.

Seconded by Dr. Rowlett.

Motion carried.

Later, five delegates arrived making a total of 110.

Delegates

ALACHUA — John E. Maines, Jr., Thomas A. Snow

BAY — William C. Roberts

BREVARD — Thomas C. Kenaston

BROWARD — Burns A. Dobbins, Jr., Donald H. Gahagen, Lloyd U. Lumpkin

COLUMBIA — Louis G. Landrum

DADE — Julius Alexander, Edward R. Annis, Morris H. Blau, Charles R. Burbacher, Turner E. Cato, Reuben B. Chrisman, Jr., Jack Q. Cleveland, Edward W. Culphier, Robert F. Dickey, L. Washington Dowlen, Herbert E. Echert, Richard M. Fleming, Edward F. Fox, W. Tracy Haverfield, Alfred G. Levin, A. Buist Litterer, John D. Milton, Frazier J. Payton, Homer L. Pearson, Jr., Warren W. Quillian, George W. Robertson, III, Ralph S. Sappenfield, Donald W. Smith, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover.

DE SOTO-HARDEE-HIGHLANDS-GLADES — James G. Smith

DUVAL — James L. Borland, Turner Z. Cason, Samuel M. Day, Jr., Frank L. Fort, A. Judson Graves, Karl B. Hanson, Charles F. Henley, Edward Jelks, Raymond R. Killingier, John F. Lovejoy, Ferdinand Richards, C. Burling Roesch.

ESCAMBIA — Jesse N. McLane, Noel C. Mellen, Walter C. Payne, Alvin L. Stebbins

FRANKLIN-GULF — (*Absent — John W. Hendrix*)

HILLSBOROUGH — Chadbourne A. Andrews, Chas. W. Bartlett, Herschel G. Cole, C. Frank Chunn, Joshua C. Dickinson, Samuel G. Hibbs, Eugene B. Maxwell, William M. Rowlett

INDIAN RIVER — James C. Robertson

JACKSON — James T. Cook, Jr.

LAKE — Sanford C. Colley

LEE-CHARLOTTE-COLLIER-HENDRY — Baker Whisnant

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON — Francis T. Holland, Robert H. Mickler

MADISON — (*Absent — Julian M. DuRant*)

MANATEE — Millard P. Quillian

MARION — John N. Moore

MONROE — Ralph Herz

NASSAU — Henry B. Dickens, Jr.

ORANGE — Chas. J. Collins, Duncan T. McEwan, John D. McKey, William S. Mitchell, Louis M. Orr, II, Frank J. Pyle, Robert E. Zellner

PALM BEACH — Charles McD. Harris, Jr., Frederick K. Herpel, V. Marklin Johnson, Ralph M. Overstreet, Jr., Cecil M. Peek.

PASCO-HERNANDO-CITRUS — S. Carnes Harvard

PINELLAS — Clyde O. Anderson, M. Eldridge Black, Raymond H. Center, Chas. L. Farrington, Albert R. Frederick, N. Worth Gable, Francis H. Langley, Norval M. Marr

POLK — Jere W. Annis, James R. Boulware, Jr., Robert J. Jahn, Bruce R. Tinkler

PUTNAM — (*Absent — Lawrence G. Hebel*)

ST. JOHNS — Hardgrove S. Norris

ST. LUCIE - OKEECHOBEE - MARTIN — Lester L. Whiddon

SARASOTA — Melvin M. Simmons, Henry J. Vomacka

SEMINOLE — Frank L. Quillman

SUWANEE — Edward G. Haskell, Jr.

TAYLOR — (*Absent — Walter J. Baker*)

VOLUSIA — C. Robert DeArmas, Joseph H. Rutter, Morris B. Seltzer

WALTON-OKALOOSA — William D. Cawthon

WASHINGTON-HOLMES — (*Absent — Baylye W. Dalton*)

ASSOCIATION OFFICERS — Herbert E. White, David R. Murphey, Jr., Richard A. Mills, Robert B. McIver, Shaler Richardson, James H. Pound (*Absent — Walter C. Page*)

On motion by Dr. Shaler Richardson, seconded by Dr. Walter C. Payne, the minutes as published in the June 1950 Journal were approved.

The Chair called for election of one delegate to the A.M.A. to serve a two year term beginning January 1, 1952 and ending December 31, 1953.

Dr. Louis M. Orr, II, was nominated by Dr. Ferdinand Richards. Dr. Duncan T. McEwan moved that nominations be closed and the Secretary cast the ballot for Dr. Orr.

Motion seconded and carried.

Dr. Orr was elected delegate to succeed himself.

The Chair called for the election of one alternate delegate to the A.M.A. to serve a two year term beginning January 1, 1952 and ending December 31, 1953.

Dr. Joshua C. Dickinson was nominated by Dr. William M. Rowlett. Dr. Edward Jelks moved that nominations be closed and the Secretary cast the ballot for Dr. Dickinson.

Motion seconded and carried.

The Chair called for the election of a third delegate to the A.M.A., the term to be two years or such portion thereof as the Association is entitled to a third delegate, beginning with the calendar year 1951. Dr. White explained that the Florida Medical Association for the first time in

its history is entitled to a third delegate. This came about because the membership has exceeded 2,001 members. This third delegate will be allowed by the A.M.A. only so long as the paid membership in the A.M.A. equals or exceeds this figure. In the event the membership falls below 2,001, this third delegate is to be dropped.

Dr. Herbert L. Bryans was nominated by Dr. Walter C. Payne.

Dr. R. Wynn S. Owen was nominated by Dr. Herschel G. Cole.

Dr. Ralph Herz moved that nominations be closed.

Seconded by Dr. Franz H Stewart.

The Chair ruled that a secret ballot was in order and appointed Drs. William C. Roberts, Richard A. Mills, Edward Jelks and William M. Rowlett as tellers.

Dr. Rowlett advised the results of the ballot: Dr. R. Wynn S. Owen, 69; Dr. Herbert L. Bryans, 38.

The Chair announced Dr. R. Wynn S. Owen as the third delegate to the A.M.A.

(May 3. — Wire from A.M.A.: "Dr. Owen not eligible not a fellow")

The Chair called for the election of a third alternate delegate to the A.M.A., the term to be two years or such portion thereof as the Association is entitled to a third delegate, beginning with the calendar year 1951.

Dr. Herbert L. Bryans was nominated by Dr. Alvin L. Stebbins. It was moved that nominations be closed and the Secretary cast the ballot for Dr. Bryans.

Motion seconded and carried.

Dr. Herbert L. Bryans was elected as third alternate delegate to the A.M.A.

The Chair announced the personnel of the three reference committees as follows:

1. HEALTH AND EDUCATION
N. E. Dining Room
Frederick K. Herpel, *Chairman*
Warren W. Quillian
Hardgrove S. Norris
William C. Roberts
Turner E. Cato
2. PUBLIC POLICY
S. W. Porch
Walter C. Payne, *Chairman*
Reuben B. Chrisman, Jr.
James L. Borland
Herschel G. Cole
C. Robert DeArmas
3. FINANCE AND ADMINISTRATION
Men's Card Room
Shaler Richardson, *Chairman*
Robert B. McIver
Homer L. Pearson, Jr.
Chas. L. Farrington
Duncan T. McEwan

The Chair announced that resolutions from the floor would be heard at this time.

Dr. John D. Milton presented a resolution urging that the 1951 session of the Florida State Legislature take cognizance of the need for refinement in admission procedures and the provision of adequate facilities for the mentally ill. This was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. John D. Milton presented a resolution regarding the appointment of qualified pathologists to serve as medical examiners instead of the present coroner system. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. John D. Milton presented a resolution regarding a proposed Anatomical Law. This was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. John D. Milton presented a resolution regarding a change of procedure in the activities of the Florida Medical Association so that the President's address would be delivered before a meeting of the House of Delegates. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

Dr. James T. Cook, Jr., presented a resolution regarding hospital standardization. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. Edward Jelks presented a resolution regarding a Certificate of Honor for Dr. Stewart G. Thompson. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

Dr. Chas. J. Collins presented a resolution regarding the licensing of hospitals, convalescent homes, etc. This was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. J. Rocher Chappell, Chairman, Advisory to Selective Service for Physicians and Allied Specialists, presented a supplemental report. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

Dr. Eugene G. Peek, Sr., Chairman of the Committee on Legislation and Public Policy, made a verbal supplemental report which was not to be recorded or published in the proceedings.

Dr. Joseph Halton, Chairman of the Committee on Necrology, sent in his supplemental report. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

Dr. James L. Anderson, Chairman of the Committee on Advisory to Woman's Auxiliary made a supplemental report. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

In addition to the above mentioned resolutions and supplemental reports, the Chair referred annual reports of standing committees and a resolution as published in the Handbook to the committees as designated with one exception. The report of the Committee on Emergency Medical Service was referred to Reference Committee No. 2 instead of Reference Committee No. 3.

Annual Reports

(To Reference Committee No. 1)

Scientific Work, Frederick K. Herpel
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton
Venereal Disease Control, Wiley M. Sams
Tuberculosis and Public Health, Erasmus B. Hardee
Maternal Welfare, E. Frank McCall
Child Health, Manuel A. Perez (deceased)

Annual Reports

(To Reference Committee No. 2)

Conservation of Vision, W. Jerome Knauer
Legislation and Public Policy, Eugene G. Peek, Sr.
Medical Education and Hospitals, Vernon A. Lockwood
Public Relations and State Education Campaign,
Joseph S. Stewart
Medical Economics, H. Quillian Jones
State Controlled Medical Institutions,
William H. McCullagh
Grievance, Walter C. Payne
Representatives to Industrial Council,
G. Frederick Oetjen
Emergency Medical Service, James L. Borland

Resolution

(To Reference Committee No. 2)

- (A) Further services State Board of Health approval of F.M.A. — Indian River County Medical Society

Annual Reports

(To Reference Committee No. 3)

Board of Governors, Herbert E. White
Interrelationship, Henry J. Peavy
Necrology, Joseph Halton
Councilor Districts and Council, Lloyd J. Netto
Advisory to Woman's Auxiliary, James L. Anderson
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell

The secretary, Dr. Robert B. McIver, requested all those who were planning to attend the Association's Annual Dinner, Tuesday evening, to please arrange to be on time in order to cooperate with the hotel management.

There being no further business, the House recessed at 10:50 a.m. to reconvene at 10:30 a.m., Wednesday, April 25, 1951.

Second House of Delegates

The House of Delegates reconvened at 10:40 a.m., Wednesday, April 25 in The Sun Room of the Hollywood Beach Hotel, Hollywood; President White in the Chair.

Dr. Louis M. Orr, II, Chairman of the Credentials Committee, was recognized and reported that there were 105 delegates present.

The Chair stated that a quorum was present.

Dr. William M. Rowlett moved that the delegates be seated.

Motion seconded and carried.

Delegates

ALACHUA — John E. Maines, Jr. (*Absent — Thomas A. Snow*)

BAY — William C. Roberts

BREVARD — Thomas C. Kenaston

BROWARD — Burns A. Dobbins, Jr., Donald H. Gahagen, Lloyd U. Lumpkin

COLUMBIA — Louis G. Landrum

DADE — Edward R. Annis, Turner E. Cato, Reuben B. Chrisman, Jr., Jack Q. Cleveland, Edward W. Culphier, Robert F. Dickey, L. Washington Dowlen, Herbert Eichert, Richard M. Fleming, Edward F. Fox, W. Tracy Haverfield, Alfred G. Levin, A. Buist Litterer, John D. Milton, Frazier J. Payton, Homer L. Pearson, Jr., Warren W. Quillian, George W. Robertson, III, Ralph S. Sappenfield, Donald W. Smith, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover. (*Absent — Julius Alexander, Morris H. Blau, Charles R. Burbacher*)

DeSOTO-HARDEE-HIGHLANDS-GLADES — James G. Smith

DUVAL — James L. Borland, Turner Z. Cason, Samuel M. Day, Frank L. Fort, A. Judson Graves, Karl B. Hanson, Charles F. Henley, Edward Jelks, Raymond R. Killinger, John F. Lovejoy, Ferdinand Richards, C. Burling Roesch

ESCAMBIA — Jesse N. McLane, Noel C. Mellen, Walter C. Payne, Alvin L. Stebbins

FRANKLIN-GULF — (*Absent — John W. Hendrix*)

HILLSBOROUGH — Chadbourne A. Andrews, Chas. W. Bartlett, C. Frank Chunn, Herschel G. Cole, Joshua C. Dickinson, Samuel G. Hibbs, Eugene B. Maxwell, William M. Rowlett

INDIAN RIVER — James C. Robertson

JACKSON — James T. Cook, Jr.

LAKE — (*Absent — Sanford C. Colley*)

LEE-CHARLOTTE-COLLIER-HENDRY — Baker Whisnant

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON — Francis T. Holland, Robert H. Mickler

MADISON — (*Absent — Julian M. DuRant*)

MANATEE — Millard P. Quillian

MARION — John N. Moore

MONROE — Ralph Herz

NASSAU — Henry B. Dickens, Jr.

ORANGE — Chas. J. Collins, Duncan T. McEwan, John D. McKey, William S. Mitchell, Louis M. Orr, II, Frank J. Pyle, Robert E. Zellner

PALM BEACH — Charles McD. Harris, Jr., Frederick K. Herpel, V. Marklin Johnson, Ralph M. Overstreet, Jr., Cecil M. Peek

PASCO-HERNANDO-CITRUS — S. Carnes Harward
PINELLAS — Clyde O. Anderson, M. Eldridge Black, Raymond H. Center, Chas. L. Farrington, Albert R. Frederick, N. Worth Gable, Francis H. Langley, Norval M. Marr

POLK — Jere W. Annis, James R. Boulware, Jr., Robert J. Jahn, Bruce R. Tinkler

PUTNAM — (*Absent — Lawrence G. Hebel*)

ST. JOHNS — Hardgrove S. Norris

ST. LUCIE - OKEECHOBEE - MARTIN — Lester L. Whiddon
SARASOTA — Melvin M. Simmons, Henry J. Vomacka
SEMINOLE — Frank L. Quillman
SUWANNEE — Edward G. Haskell, Jr.
TAYLOR — (*Absent — Walter J. Baker*)
VOLUSIA — C. Robert DeArmas, Joseph H. Rutter, Morris B. Seltzer
WALTON-OKALOOSA — William D. Cawthon
WASHINGTON-HOLMES — (*Absent — Baylye W. Dalton*)
ASSOCIATION OFFICERS — Herbert E. White, David R. Murphey, Jr., Richard A. Mills, James H. Pound, Robert B. McIver, Shaler Richardson. (*Absent — Walter C. Page*)

Dr. White: "I take pleasure in introducing to the House of Delegates a Parliamentarian for myself, Dr. Arthur H. Weiland. Dr. Weiland had to go to Tallahassee yesterday on important business and could not be here at the first meeting of the House. I am happy to announce that he is here. Arthur, stand up and take a bow."

Dr. White: "First, we will have the recommendations of Reference Committee No. 1, Health and Education, Dr. Frederick K. Herpel, Chairman."

Report of Reference Committee No. 1

Dr. Herpel: "Your Reference Committee No. 1 has considered the written reports of several committees and in addition, three resolutions submitted yesterday, two by Dade County Medical Association and one by the Obstetric and Gynecologic Society. All members of the Committee were present at the meeting which was held in the N. E. Dining Room."

Dr. Herpel: "With reference to the annual report of the Committee on Scientific Work we recommend approval of the report. I think the attendance at the Scientific Assemblies is sufficient recommendation for the continuance of this particular type of activity."

Dr. Herpel: "I move that this report be adopted."

Motion seconded and carried.

Report of Committee on Scientific Work

Frederick K. Herpel, *Chairman*

Your committee has functioned since the last annual meeting in securing physicians to present papers for the scientific assemblies of the annual meeting of 1951. The program which has been prepared for your consideration is the best obtainable after diligent work on the part of the committee.

All presidents of component county medical societies were contacted early in the year's work, urging them to present to their membership a cordial invitation to participate in the work of the scientific assemblies. The number of applications for places on the program was disappointingly small in number, and the distribution of the papers not as wide as had been anticipated. Nevertheless we hope that you will find in the program much of interest, and it is our sincere wish to share with you the results of work and study on the part of the physicians who have prepared these discussions and papers for you.

Your committee, throughout the past several years, has avoided going directly to individual physicians and asking them to prepare a paper for the state meeting, and asking rather for volunteers for these places on the scientific program, which should be considered a place of honor, and a recognition of work well done. This method has obviously failed to produce the number of papers desired, embarrassing the committee in its selection of outstanding programs.

Your chairman wishes to express his thanks to all who have participated in the preparation of this program.

Respectfully submitted,

Frederick K. Herpel, *Chairman*

Dr. Herpel: "The report of the Committee on Medical Postgraduate Course — Reference Committee No. 1 recommends approval of this report by Dr. Turner Z. Cason, Chairman, with special commendation for the excellent work of his committee. I move that it be adopted."

Motion seconded and carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The Eighteenth Annual Graduate Short Course for doctors of medicine was held in Jacksonville, June 26-July 1, with a total attendance of 204 physicians.

The annual Tuberculosis Seminar was held in Orlando, May 24-26, with a total attendance of 62, 28 of whom were physicians.

The annual Diabetes Seminar was held in Jacksonville on March 20-21, with 33 physicians in attendance.

The Special Graduate Short Course was held in Jacksonville with 53 physicians attending.

The faculty, location and outline of the programs for the preceding courses, which were approved by the Medical Postgraduate Course Committee, were decided and prepared by the Department of Medicine of the Graduate School of the University of Florida.

A Seminar on Cancer was held in DeFuniak Springs on May 24, in Tallahassee on May 25, in Gainesville on May 26, in Daytona Beach on May 29, in Arcadia on May 31, and in Sarasota on June 1. A total of 150 physicians attended these one day sessions. The course was prepared by the Florida State Board of Health.

The annual Ophthalmology and Otolaryngology Course was held in Miami on January 16-21, with a total attendance of 160.

The Medical Postgraduate Course Committee met at the George Washington Hotel, Jacksonville, on August 27. Dr. T. Z. Cason, chairman, and Dr. George M. Dawson were present. Also present was Dr. K. E. Miller, who represented the State Board of Health.

At this meeting the schedule for the courses to be presented during the fiscal year was discussed and the tentative outline as to time and place was approved.

The Faculty List of the Department of Medicine was also discussed at the meeting and it was requested that any recommendations or revisions be submitted. The following new members were approved: Dr. David R. Murphey, Jr., Tampa, Department of Surgery; Dr. C. Frank Chunn, Tampa, Department of Thoracic Surgery; Dr. J. Brown Farrior, Tampa, Department of ENT.

The instructors for the Short Course and the type of lectures were considered and the outlines of the courses were approved.

An increase in the honorarium for the instructors of the Short Course was discussed. It was decided that an additional day's honorarium be allowed for the travel day to and from the course.

The issuance of certificates of attendance to physicians attending these postgraduate courses was approved. The

certificates have been printed and the first of these signed and issued. In the future certificates will be issued following each course.

The Statement of Receipts and Disbursements, from July 1, 1949 to July 1, 1950, was presented at the meeting. It showed that receipts from registration fees was \$2,095.00, to which was added the Florida Tuberculosis and Health Association's assistance check of \$300.00, making a total of \$2,395.00. The expenses for that same period, which do not include the expense of \$478.55 incurred by the Florida State Board of Health to cover the honorariums and expenses for the pediatrician, gynecologist and obstetrician participating in the 1950 Short Course, amounted to \$1,688.97. The balance on hand on July 1, 1950, was \$1,823.74.

For the first time the University auditor is auditing the accounts of the Short Course fund and is revising the accounting system to comply with the other departments of the University of Florida.

Respectfully submitted,
Turner Z. Cason, *Chairman*

Dr. Herpel: "The report of the Committee on Cancer Control — There is one item in this report which might be controversial and about which there was considerable discussion and that is the formation of a Florida Cancer Council which will have as its function, without other than recommending powers or advisory powers, the over-all planning of additional programs in the State and the other phases of cancer control and cancer education and aim at eliminating the duplication of effort in regard to education in the field of cancer work. There was no objection by our committee and we are in favor of approval of this report. I move that this report be adopted."

Seconded by Dr. Richardson.

Motion carried.

Report of Committee on Cancer Control

Frazier J. Payton, *Chairman*

Although no formal meeting of all the members has been held because of difficulty of assembly, it has, nevertheless, become increasingly apparent to your committee and to others that there is a great need for an overall co-ordinating Cancer Control Committee, or other named body, in the State of Florida to incorporate the interests, information and activities of related endeavors by other than the Florida Medical Association. To this end your committee has bent its efforts with the mutual efforts of the State Board of Health, the state representative of the American College of Surgeons and the Florida Division of the American Cancer Society.

A "Florida Cancer Council" has been formed as a co-ordinating body in an attempt to eradicate over-lapping of activities which have been to the detriment of and, in some instances, have even encouraged neglect of portions of the most desirable cancer control program for the state. This co-ordinating committee has the official approval of the President of the Florida Medical Association, the Florida State Board of Health, the American College of Surgeons, state and national, and the Board of Directors, Florida Division, American Cancer Society.

At its January meeting, the Board of Governors of the Florida Medical Association approved its formation and recommended approval by the House of Delegates. It is to be understood that this co-ordinating Council is not to replace the Cancer Control Committee of the state medical society, but rather it is hoped that continuity of effort of

the Florida Cancer Council will be maintained by appointments from the Cancer Control Committee of the Florida Medical Association, as expiration of the medical association members occur.

President Herbert E. White has appointed as the initial representatives from the Cancer Control Committee, Dr. Frazier J. Payton and Dr. George W. Morse to serve during the tenure of their offices in the Cancer Control Committee of the Florida Medical Association. Other appointees are as follows: by the Florida State Board of Health, Dr. Wilson T. Sowder, State Health Officer, and Dr. Lorenzo L. Parks, director of the Bureau of Preventable Diseases; for the American College of Surgeons, Dr. Duncan T. McEwan; for the Florida Division of the American Cancer Society, Dr. Ashbel C. Williams and Dr. C. Frank Chunn.

The proposed functions of the Florida Cancer Council are to promote both the lay and physician educational activities, to encourage the development of and to advise county and state organizations concerned with Cancer Control, to co-ordinate all Cancer Control work in the state, so that facilities may be used more economically and effectively, and to investigate additional sources of revenue of local, state and federal origin to improve cancer control activities. Specific problems involved cannot be detailed because of lack of space.

The formation of the Florida Cancer Council as above outlined is recommended to the House of Delegates of the Florida Medical Association for approval.

Respectfully submitted,
Frazier J. Payton, *Chairman*

Dr. Herpel: "Report of the Committee on Venereal Disease Control is approved with attention called to the last paragraph of the report stressing the continued importance of instruction in the field of venereal disease. I move that this report be adopted."

Motion seconded and carried.

Report of Committee on Venereal Disease Control

Wiley M. Sams, *Chairman*

In no period of history have advances in medical science appeared with greater frequency than in the past decade. This is particularly true in the field of contagious and infectious diseases, especially those of bacterial origin. The ultimate goal of medical science is to cure and prevent disease. The treatment of the venereal diseases has been immeasurably improved since the advent of antibiotic therapy. Serious reactions to treatment have been almost eliminated. Nonetheless, the time to boast has not arrived, for there is much work yet to be done.

When the statistics of venereal diseases are reviewed, we find that the war years, with the disruption and transfer of large segments of population, have always led to epidemics and increased numbers of patients infected with venereal disease. These years are followed by a period in which there is a declining incidence of venereal disease. This cycle was noted before the arsphenamines, sulfonamides and antibiotic drugs had made their advent in therapeutic science. It is likely then, that in spite of our superior drugs for treatment, that we will experience an increase in the incidence of venereal disease when we again build a military organization with three, four or five million members. A displacement of so many people from their usual environments can only multiply the chances for infection, and lead to dissemination of all contagious diseases.

Our current organization in the Public Health Service, the State Health Departments and the various municipal and county health departments, was developed during the last war. This program was organized at a time when

rapid treatment for gonorrhea and syphilis had not been established. The one day and five day "cures" by the administration of massive doses of mapharsen and the use of fever therapy were then in experimental use. Rapid Treatment Centers were organized throughout the nation in an attempt to rehabilitate infected personnel and drafted men as rapidly as possible. It soon became evident that our then accepted program of eighteen months for the treatment of syphilis was not practical. Although effective if carried out, a very high percentage of patients failed to complete treatment. The advent first of sulfonamides in the treatment of gonorrhea, rapidly followed by the use of penicillin in the treatment of both syphilis and gonorrhea, has entirely altered our conception of the treatment and cure of both diseases. The methods of treatment have become simplified, are available now to every physician, and the value of special clinics for the treatment of venereal disease, other than the indigent patient, is open to question.

A review of statistics from our local County Health Department in the years of 1949 and 1950 shows a continued decline in the incidence of venereal diseases. This is most marked in the case of syphilis in which the number of darkfield positive cases dropped from 106 in 1949 to 44 in 1950. Similar declines were noted in the incidence of chancroid, lymphopathia venereum, and granuloma inguinale. The smallest decline was found in gonorrhea, where the number of new cases reported decreased by approximately 16 per cent.

In spite of this rapid decline, there is still need for instruction in the field of venereal diseases in our medical schools and hospitals. The medical student and our residents and interns, whether they enter government service or private practice, and do general or specialty work, cannot lose sight of the venereal disease problem if they are to be competent in the field of diagnosis and treatment. The interpretation of laboratory reports on venereal disease problems, the ability to discern the various manifestations which these diseases produce, and their potentiality for late complications, deserve our careful attention and our best efforts, in order that we may avoid erroneous interpretations and treatment pitfalls. Our program for the control and treatment of venereal disease must be reoriented to fit our present therapeutic advances. The time required for treatment is now short, the expense involved is no longer beyond the means of the average patient, and the means for optimum treatment are in the hands of every physician. Tracing infectious contacts and follow-up examinations of previously treated infectious patients should receive major emphasis.

Respectfully submitted,
Wiley M. Sams, *Chairman*

Dr. Herpel: "Report of the Committee on Tuberculosis and Public Health — The report of this committee was the subject of some discussion by numerous persons who appeared before the committee. There is no difference in the intent and purport of the recommendations made in the last two paragraphs by Dr. Hardee, however, the committee recommends approval of the report with the following amendments: That the last sentence of paragraph 4 of the report be deleted, and read as follows: 'Therefore, this Committee recommends that Rh factor determinations by the State Board of Health be limited to specimens submitted from recognized Maternal Health and Welfare Clinics' patients, and further that specimens obtained by private physicians from non-clinic medically indigent patients shall be sent for Rh factor

determination to a private clinical laboratory for such examination, without charge to patient or physician.' That the following be added at the end of the report of this committee: 'It is further recommended that such programs of admission chest survey examinations be under the supervision and direction of the radiological departments of such hospitals, the details of examination, and possible charge therefor to be worked out by the radiologist and the hospital authorities.'"

Dr. Herpel: "I move the adoption of this report as amended."

Seconded by Dr. Herz.

Motion carried.

Report of Committee on Tuberculosis and Public Health

Erasmus B. Hardee, Chairman

Your Committee on Tuberculosis and Public Health has had two meetings during the past year. Our first meeting was in May, at which time we were asked to supervise the case findings of the Diabetic Division of the State Board of Health.

The second meeting was in January of this year, at which time we met with the representatives of the various specialty societies, with regard to the State Board of Health doing Rh factor determinations on private patients.

Your chairman and members of the Committee have attended meetings of the Directors of the Tuberculosis and Health Associations throughout the past year. This Committee has functioned closely with the State Tuberculosis Board, the Tuberculosis and Health Association and the State Board of Health.

At the last meeting of your Committee, the pathologists of the State, through their President, agreed to make Rh factor determinations on private patients on a pro-rata basis. Therefore, this Committee recommends that Rh factor determinations by the State Board of Health be limited to specimens submitted from recognized Maternal Health and Welfare Clinics' patients, and further that specimens obtained by private physicians from non-clinic medically indigent patients shall be sent for Rh factor determination to a private clinical laboratory for such examination, without charge to patient or physician.

Your committee recognizes the value of admission chest x-ray programs in general hospitals, both as a method of finding cases of tuberculosis and as a means of protecting hospital personnel and patients from unsuspected cases. The Committee looks with favor on such programs and recommends their initiation whenever and wherever possible in hospitals having one hundred or more beds.

It is further recommended that such programs of admission chest survey examinations be under the supervision and direction of the radiological departments of such hospitals, the details of examination, and possible charge therefor to be worked out by the radiologist and the hospital authorities.

Respectfully submitted,
Erasmus B. Hardee, *Chairman*

Dr. Herpel: "The report of the Committee on Maternal Welfare is approved with commendation for the enthusiasm displayed by this committee and its chairman in the proposed extended program of lay education. I move acceptance of this report."

Motion seconded and carried.

Report of Committee on Maternal Welfare

E. Frank McCall, *Chairman*

Your committee spent considerable time and thought on a practical method of reducing the maternal mortality in the State of Florida. The program, of necessity, must be a long range one and it may not show a material decrease in mortality for the past year.

A Postgraduate Short Course in Obstetrics was arranged which was designed for the general practitioner through the cooperation and financial aid of the Florida State Board of Health and the Postgraduate School of the University of Florida. This meeting was an experimental one and was limited to doctors in the northeastern part of Florida. Dr. W. J. Dieckmann, Professor of Obstetrics, University of Chicago, was our guest for this meeting, and many of the local doctors participated in the course. Except for two didactic lectures each day, the remainder of the time was spent in round table discussions of the current problems that beset a general practitioner doing obstetrics. This course was well received by those who attended and plans for the coming year include four such courses to be held in strategic spots in Florida. The course will be similar to the one held in Jacksonville last June, in that it will have an outstanding guest speaker and most of the discussion will be round table.

An effort is being made to establish a Maternal Welfare Committee in each city of any size in the state; the prime function of these committees being to study the local maternal deaths. Most of the local committees are holding open reviews. Their aim is not one of condemnation but of education.

Your chairman is in the process of making a documentary type film with color and sound at a cost of about \$2,000 which is designed to be shown to lay women throughout the state. (To aid in the advancement of education to lay women, I am donating the film.) This film dwells primarily on prenatal care and the prevention rather than the cure of most of the chief causes of maternal death.

The midwife problem is still a very important one in this state in regards to maternal mortality. As yet, no good workable plan has been devised to eliminate the midwife. It must be done eventually if the mortality is to be reduced.

Summary: (1) An experimental short course for the general practitioner, (2) an effort, through film, to educate women of the child-bearing age, (3) to spread our short courses over the state so that every general practitioner and specialist may take advantage of them.

Respectfully submitted,
E. Frank McCall, *Chairman*

Dr. Herpel: "The report of the Committee on Child Health presented by its chairman, recently deceased, is approved with special attention invited to the second paragraph of the report in connection with the program of premature care. Your committee notes with regret the recent death of the chairman of this fine committee. I move adoption of this report."

Motion seconded and carried.

Report of Committee on Child Health

Manuel A. Perez, *Chairman*

The work of your Committee on Child Health during the past year has been largely devoted toward the continuance of the excellent work done by your previous Committees, and has been directed principally at cooperating fully with the various agencies throughout the state interested in Child Health and Welfare. These agencies include among others, the Bureau of Maternal and Child

Health of the State Board of Health, the Florida State Pediatric Association, American Academy of Pediatrics, the Florida Crippled Children's Commission, the Cerebral Palsy Association, and many others.

Your Committee on Child Health has not found it necessary to call a formal meeting during the past year. Your chairman has had numerous informal talks with the other members of this Committee on various occasions, but especially at the Annual Meeting of the Florida State Pediatric Association held at Daytona Beach during the month of October. Correspondence has been carried on with the Chairman of the State Bureau of Maternal and Child Health of the Florida State Board of Health in an effort to keep well informed on the various programs and activities which are at present being carried out throughout the State of Florida. A considerable amount of emphasis has been placed on the Premature Care Program. In this connection we wish to mention the establishment of the Premature Care Demonstration Center at Jackson Memorial Hospital in Dade County which has a special appropriation of \$50,000 per year through July 1, 1953. The need for this program is well shown by the fact that Florida ranks forty-third in the nation when premature infant mortality rate is considered. The State Committee on the Foetus and Newborn is doing excellent work in connection with this problem and your Committee has promised full cooperation in helping them carry out their well planned program.

A committee from the Florida Pediatric Association has been working in conjunction with the State Crippled Children's Commission on their cerebral palsy program and this Committee has offered to help in anyway possible.

Some consideration should be given to the Hearing program and to the program now conducted for Visual Acuity tests in the school systems.

The Epilepsy Institutes conducted during April and October 1950 deserve special mention.

In regards to the Heart Program we may mention that facilities are now available within the State of Florida to carry out diagnostic procedures on congenital heart cases.

The various civic organizations throughout the state, as well as the Parent-Teacher Associations, and the Junior League are showing an ever increasing interest and desire to participate and help with the problems of child health in the State of Florida. Some are definitely interested in the Mental Health program, others in the Milk Bank, and still others in the Visual and Hearing programs. It is the feeling of this Committee that all of these agencies can be very helpful in promoting child health as well as in the purchase of badly needed equipment in some areas. However, it is felt that a lot of these organizations are badly in need of proper medical advice and guidance, so that they may direct their efforts in the proper channels or where they will do the most good. The members of this Committee recommend that every possible effort be put forth in enlightening them so that all may join forces for the common good, namely, child health in Florida.

In conclusion, this Committee wishes to pledge itself to continue working ardently on the present programs concerning child health in Florida. No recommendations on any new program are being made at this time as they are not deemed feasible.

Respectfully submitted,
Manuel A. Perez, *Chairman*

Dr. Herpel: "On the resolution presented by the Dade County Medical Association with reference to admission procedures and adequate facilities for the mentally ill, we recommend approval of this resolution. I move that it be adopted."

Seconded by Dr. Rutter.

Motion carried.

Resolution

WHEREAS, the admission procedures and institutional and other facilities for the handling of the mentally ill of the State are recognized to be woefully inadequate, and

WHEREAS, surveys and studies looking toward the solution of these problems should be initiated and progressed at the earliest possible date.

NOW, THEREFORE, BE IT RESOLVED: That the Florida Medical Association does urge the 1951 session of the Florida State Legislature to take cognizance of the need for refinement in admission procedures and the provision of adequate facilities for the mentally ill of the State of Florida and to initiate studies, surveys and procedures looking toward a solution of these problems.

Dade County Medical Association

Jack Q. Cleveland, *President*

R. B. Chrisman, Jr., *Secretary*

Unanimously passed at the Regular Monthly Meeting this 3rd day of April, 1951, for submission to the FMA House of Delegates.

Dr. Herpel: "On the resolution presented by the Dade County Medical Association with reference to the proposed Anatomical Law for the State of Florida, this resolution is approved by the reference committee and we recommend its adoption. If this state is to have a medical school in the future, it seems essential that such facilities be available well in advance of the establishment of the medical school in order that the Department of Anatomy may operate. The Committee felt that it was a very fine thing to anticipate our problems. I move the acceptance of this resolution."

Seconded by Dr. Herz.

Motion carried.

Resolution

BE IT RESOLVED BY THE FLORIDA MEDICAL ASSOCIATION: That it does hereby approve the proposed Anatomical Bill attached hereto and does direct that it be submitted to the FMA House of Delegates.

Dade County Medical Association
Jack Q. Cleveland, *President*

Unanimously passed at the Regular Monthly Meeting this 3rd day of April, 1951, for submission to the FMA House of Delegates.

Dr. Herpel: "This resolution presented by the Florida Obstetric and Gynecologic Society recommends that our Legislative Committee be instructed to initiate legislation whereby the licensing of hospitals shall be placed under the supervision of the State Board of Health. The reasons for this resolution are, I think, quite evident, if you will stop and think that there are many convalescent homes, nursing homes and small hospitals that have no supervision. If the State Board of Health is expected to examine restaurants and food handlers, then we can not afford to disregard these institutions which are caring for patients. I move the adoption of this resolution."

Seconded by Dr. Langley.

Motion carried.

Resolution

The Florida Obstetric and Gynecologic Society recommends to the Florida Medical Association via its Legislative Committee that necessary study be made and state legislation instituted whereby all hospitals, sanitariums, homes and facilities for patients under the care of practitioners of the healing arts be regularly licensed by the State Board of Health in accord with minimal standards of equipment, operation and care with respect to each type of patient (as medical, surgical, obstetric, mental, convalescent, boarding, etc.).

Report of Reference Committee No. 2

Dr. Walter C. Payne, Chairman of Reference Committee No. 2, was recognized and asked to present the recommendations of that committee.

Dr. Payne: "Your Reference Committee No. 2, Public Policy, wishes to make the following report."

Dr. Payne: "The report of the Committee on Conservation of Vision by Dr. W. Jerome Knauer, Chairman, is approved and I move adoption of this report."

Seconded by Dr. Richardson.

Motion carried.

Report of Committee on Conservation of Vision

W. Jerome Knauer, *Chairman*

Every member of this Committee has been contacted for new ideas and the majority feel that the publishing of articles for lay reading, relative to vision and in prevention of loss of vision is an ideal action for this group and this has been carried out during the year.

Diabetes and glaucoma have been taken up as the subjects which we felt the public needed most to have attention called. Perhaps the Committee next year can take up other subjects they feel that are important.

The opticians have been contacted as per recommendations of last year's committee and in the majority of cities prices have been stabilized for glasses and I believe a cordial relationship between the ophthalmologist and opticians exists. This is being further pursued.

Respectfully submitted,

W. Jerome Knauer, *Chairman*

Dr. Payne: "The report of the Committee on Legislation and Public Policy by Dr. Eugene G. Peek, Sr., has been studied, your committee approves. I move adoption of the report."

Seconded by Dr. Stebbins.

Motion carried.

Report of Committee on Legislation and Public Policy

Eugene G. Peek, Sr., *Chairman*

The chief activities of your Committee have been the planning and preliminary work for the 1951 Session of the Florida State Legislature.

As directed by action of the House of Delegates, President White called a joint meeting of the Board of Governors, Members of the House of Delegates, Bureau of Public Relations and the Committee on Legislation and Public Policy on January 28, 1951 in Ocala for the purpose of planning a definite legislative program (June Journal, page 756, second column). Your chairman presented a proposed legislative program which was the product of several meetings of the Legislative Committee during the year. The legislative program was discussed by the members present at this meeting.

As was done at the last session of the legislature, an office will be maintained at Tallahassee during April and May. This office is for the convenience of the legislators and others who may seek information on problems concerning medicine, health and education as they effect legislation for the protection of Florida citizens.

Every member of the Association is urged to keep himself informed on bills introduced in the Congress and at the Florida Legislature. Contact your State and County Committees frequently for information. It is very important that we all act promptly when requested by those who represent us. If you are called on to appear before a Committee of the Senate or House, please obtain all possible information on the bill under consideration in order that you may not be embarrassed by finding later that your opinions were not based on facts. Giving a hasty opinion without due knowledge of the wording of a bill often causes more damage than good and therefore puts the entire medical profession in a bad light.

After the election a cumulative card record was brought up to date on each Senator and Representative and pertinent information has been recorded.

A copy of "Today's Health" (formerly "Hygeia") is again being sent to Florida's United States Senators, Representatives, the Governor, his cabinet, and to each State Senator and Representative. Letters have been received from many recipients of this favor expressing their appreciation.

Your chairman and others from Florida represented the Association at the AMA Regional Conference on Legislation held in Atlanta on October 26, 1950. Health legislation likely to be introduced in the 82nd Congress was reviewed. Dr. Joseph Lawrence of the AMA's Washington Office presided. Your Committee has cooperated with the Washington Office in every way possible.

Your Committee desires to express appreciation for the assistance given by the President, Secretary, other State Association officers, Managing Director, his Assistant and Bureau of Public Relations; to the officers and members of the Legislative Committees of the County Medical Societies, and to many individual doctors who have responded when called on for assistance.

Respectfully submitted,

Eugene G. Peck, Sr., *Chairman*

Dr. Payne: "The report of the Committee on Medical Education and Hospitals has been studied. I move the adoption of the report."

Seconded by Dr. McLane.

Motion carried.

Report of Committee on Medical Education and Hospitals

Vernon A. Lockwood, *Chairman*

During the year your committee stood ready to consider any problems that might be referred to it. It was not deemed necessary to hold a committee meeting under the circumstances, but your chairman, personally communicated with each member of your committee inquiring if any subject had been brought to his attention that might deserve the consideration of the committee.

The list of hospitals published in the 1951 Florida Medical Directory was approved for publication, listing 152 hospitals, sanatoriums and related institutions in Florida. At the top of this list, the following statement appeared: "The inclusion of any institution may be taken as indication that evidence concerning irregular or unsafe practices in that institution has not come to the attention of the committee on Medical Education and Hospitals."

Special Assignment

1. Rural Medical Service. There has been considerable activity headed by the American Medical Association on Rural Medical Service. A field worker visited Florida and described the efforts being put forth to furnish medical care in rural districts. There was a meeting in Chicago but it was impossible for any member of your committee to make the trip.

Respectfully submitted,

Vernon A. Lockwood, *Chairman*

Dr. Payne: "The report of the Committee on Public Relations and State Education Campaign by Dr. Joseph S. Stewart, Chairman, has been carefully studied and we feel it is an excellent report. I move adoption of this report."

Seconded by Dr. DeArmas.

Motion carried.

Report of Committee on Public Relations and The State Education Campaign

Joseph S. Stewart, *Chairman*

During February 1950 the American Medical Association held another meeting of its Committee of Fifty-three in Chicago. Following this meeting, the State Education Committee held a meeting in Jacksonville which was well attended by representatives of all the County Medical Societies and the Auxiliary. This meeting was similar to the one held on March 13, 1949.

Florida Medicine has made a name for itself Nationally during the past year from a Public Relations and Education Campaign Committee standpoint. Several of the members of our Association have been invited to various cities throughout the United States to speak on what Florida had done and how she had done it.

During December 1950 the American Medical Association held its third annual Public Relations conference and meeting of the Committee of Fifty-three. Florida was well represented at this meeting and all of us who attended felt that we had had one more post-graduate course in what to do in regard to public relations and the Campaign of Education.

Your Committee arranged for one hundred showings in commercial theatres of Florida of the ten minute sound motion picture entitled, "To Your Health."

Florida Medical Association sponsored the Essay Contest for school children of Florida on the subject, "Why The Private Practice of Medicine Furnishes This Country With The Finest Medical Care." The various County Medical Societies cooperated beautifully and as a result it is felt that we should continue this Essay Contest. As a matter of interest, the second prize winner of Florida placed third in the National Contest.

Your Committee is proud of the way in which the County Medical Societies backed up the American Medical Association's National advertising campaign during October 1950.

During the 1950 session of the Florida Medical Association your Public Relations Committee asked for criticisms and suggestions. To our delight many members came by the booth and offered many criticisms of great value. As a result of the information thus obtained, your Committee published a booklet entitled "A Public Relations Program" and a copy was sent to every member in July of 1950.

Mr. Harold Parham, the supervisor of your Bureau of Public Relations, has spent most of his time in the field during the past year, assisting in every way possible the County Medical Societies. Mr. Parham has been able to bring us in closer relationship to the newspapers, radio stations, civic and allied organizations of the State, and to coordinate Public Relations programs among the various County Medical Societies.

A few of the activities of the supervisor of the Bureau of Public Relations are listed below.

Electrical Transcriptions: Seventeen radio stations of Florida have broadcast 658 health subject transcriptions of 15 minute duration furnished them by the State Public Relations Committee in cooperation with the County Medical Societies. A large majority are broadcast as a public service by these stations and the others have commercial sponsorship.

Health Topics: As a service to weekly newspapers each week, timely health subjects are mailed to 85 newspapers of Florida, many of whom publish them as a public service.

News Releases: News items of interest are prepared as occasions warrant and released to the newspapers and radio stations in the state.

Briefs: National, state and local information of interest to the membership is disseminated in this manner as a news letter to the doctors.

Exhibit Booth: A Public Relations booth is maintained during the Association's Annual Convention to disseminate information and receive criticisms of the public relations program.

Campaign Literature: Educational material consisting of over 871,046 pieces has been distributed in Florida since the beginning of the education campaign in an effort to exercise the spectre of socialized medicine now confronting this country.

At the present time, arrangements are being made to put on a thirty minutes television broadcast in the only two television outlets in Florida, that is, Jacksonville and Miami. The results of this activity will be reported later in a supplementary report.

Your Committee feels, and would like to state again, that Florida Medicine has the right to be proud of the part it has played during the past two years in educating the public to what medicine means and in all public relations activities. The formation of a State Grievance Committee, with local grievance committees in the various county societies, is a great step forward. Practically all of the larger county societies have formed Medical Service Bureaus in an effort to assist the public in getting in touch with doctors day and night during emergencies. We have done well and we are growing beautifully, but we must not stop. Everything we do in the Public Relations line, or in relation to the Committee on Education costs money and I believe that the greatest lesson we can learn from what has happened during the past two years is that each doctor must contribute to his local, to his State, and to his National Medical Association in order that this work may be continued.

Respectfully submitted,
Joseph S. Stewart, *Chairman*

Dr. Payne: "On the report of the Committee on Medical Economics, your committee wishes to make certain amendments. You will find this report on page 27 in the Handbook. The committee recommends that the second paragraph, Item 1, be deleted because it is based on opinion rather than actual study; and that Item 4 be deleted because there is another committee for this purpose. With the deletion of Items 1 and 4 by amendment, I move adoption of this report."

Seconded by Dr. DeArmas.

Motion carried.

Report of Committee on Medical Economics

H. Quillian Jones, *Chairman*

In an attempt to gather data toward making this report, your committee contacted, through correspondence, every medical society in the state. Replies gave the following information:

2. Even though voluntary health insurance has developed quite rapidly, there is need to push it more vigorously, especially in the smaller counties.

In order to prevent any misunderstanding as to what medical expenses are covered by insurance, it is urged to have, in some way, a better liaison among the physicians, hospitals, patients and insurance carriers.

3. The broader establishment of blood bank units with participating communities augurs well to help materially to reduce the high cost of transfusions to the middle-class people.

5. Credit business is increased and collections slower, yet economic conditions generally over the state are good.

Respectfully submitted,
H. Quillian Jones, *Chairman*

Dr. Payne: "The report of the Committee on State Controlled Medical Institutions — We think this is an excellent report. I move its adoption."

Seconded by Dr. Simmons.

Motion carried.

Report of Committee on State Controlled Medical Institutions

William H. McCullagh, *Chairman*

The Committee on State Controlled Medical Institutions wishes to report first on the status of the Florida State Hospital. The most outstanding change that has occurred within the past report period has been in the administration of the Florida State Hospital. This resulted on the death of Dr. J. H. Therrell which occurred in October 1950. For more than 13 years, Dr. Therrell was the superintendent of this hospital and proved to be a very able administrator, especially as regards the financial affairs of the institution. Although not a young man and not in the best of health for some time before his death, nevertheless, the suddenness of his death was a surprise and he will be greatly missed.

The vacancy of this position made possible the appointment of a successor whose qualifications we feel sure meet the approbation of the entire Association. Prior to this selection, however, your Committee conferred with the President of the Florida Medical Association and with a number of other members whose judgment in such matters was considered most desirable. It was decided by all that the ideal superintendent should be a doctor of medicine with both administrative and psychiatric experience, as well as one who was familiar with this particular institution and also enjoyed the esteem of our State Civil Authorities. It so happened that such a well qualified man was available in the person of Dr. W. D. Rogers, who joined the medical staff of that hospital in 1935 and since 1940 had been the Chief Physician continuously. It is a matter of general knowledge that he has served admirably in that capacity. Reinforced in this opinion the Chairman of your Committee personally appeared before the Governor and his cabinet at the State Capitol in Tallahassee at which time the importance of the superintendent being a physician was primarily stressed and the above previously mentioned qualifications of Dr. Rogers were brought out. At this meeting the cabinet seemed immediately impressed and proceeded at once unanimously to approve the appointment of Dr. W. D. Rogers as the Superintendent of the State Hospital in which position he is notably serving. It is our firm belief that this is a fortuitous selection and one that will result in the State Hospital making great strides in the future.

The other State Controlled Institution investigated by your Committee is, of course, the Florida Farm Colony in Gainesville. It is a matter of continuing regret that the facilities of this institution are entirely inadequate for the needs of as rapidly a growing state as Florida. It is still difficult to obtain early admittance to this Institution due to the lack of beds and facilities, but it is realized that this is a situation that can be overcome by the appropriations of sufficient funds by the legislature. It is gratifying to find that other civic minded groups are being interested in this same problem and it is, therefore, hoped that this will result in early benefits to this particular institution. It should also be mentioned that there still remains the urgent need for the creation of an institution to provide adequately for similar type of cases occurring in our Negro population.

Respectfully submitted,
William H. McCullagh, *Chairman*

Dr. Payne: "The report of the Committee on Grievance has been studied. I move adoption of this report."

Seconded by Dr. Richardson.

Motion carried.

Report of Grievance Committee

Walter C. Payne, *Chairman*

The House of Delegates of the Florida Medical Association at the 1950 annual session passed a resolution creating a State Grievance Committee (June Journal, page 765) composed of the five immediate past living presidents. Pursuant to this action, a meeting of the Committee was held at Ponte Vedra Beach, Aug. 26, 1950. At this meeting tentative rules and regulations were adopted and sent to the American Medical Association for criticism and legal advice. Another meeting was held in Jacksonville on Jan. 13, 1951 when permanent rules and regulations were adopted.

Following the announcement of the resolution creating this Grievance Committee, complaints began to be received immediately. Unfortunately, this Committee was not in a position to handle these complaints at once for obvious reasons. Rules and regulations had to be written and adopted. It was necessary for each county medical society to create a county grievance committee and to adopt rules and regulations. Shortly, a copy of the State Grievance Committee rules and regulations will be sent to each county society for its information and guidance.

Your Committee would like to suggest in so far as possible the county grievance committees pattern their rules and regulations similar to the state rules and regulations. It is suggested also that the appointment of the personnel of the county committees be staggered as it is felt that some of these committees should at all times be familiar with the duties and functions of the State Committee.

It is the policy of the State Committee to refer all complaints to the various county societies for adjudication. The State Committee will keep a record of all complaints and act as an appeal board.

So far, fifteen complaints have been received, but due to the delay necessitated by getting our organization set up, most of the complaints have not been satisfied. We do not feel too discouraged, however, as we feel that from now on we shall be in a position to expedite the handling of these complaints.

We believe that in next year's report we shall be able to report in detail the results of our efforts. We hope that we shall be able to state that a large percentage of complaints have been settled in a manner satisfactory to complainant and the member against whom the complaint was filed.

Respectfully submitted,
Walter C. Payne, *Chairman*

Dr. Payne: "The report of Representatives to Industrial Council has been studied carefully. I move adoption of the report."

Seconded by Dr. McLane.

Motion carried.

Report of Representatives to Industrial Council

G. Frederick Oetjen, *Chairman*

Last fall I had a conference with Dr. J. F. McCahan, Assistant Secretary of the Council on Industrial Health of the American Medical Association. Objectives by the Council were discussed at length. The Council believes that the development of County Committees on Industrial Health would widen the Association's influence in the

field of Industrial Health, a field in which the Association could launch a counter-offensive against the proponents of government controlled medicine.

No official meeting has been held so far with the members of Representatives to Industrial Council. When problems arise views of the other members are obtained through correspondence. While there has not been the necessity of holding a meeting, I desire to thank the members of this group for standing by ready for consideration of whatever may be presented. The other members are Edward W. Cullipher, Charles Larsen, Jr., Julius C. Davis and Chas. L. Farrington.

The eleventh annual congress on Industrial Health will be held in Atlanta, Georgia, at the Atlanta Biltmore Hotel, February 26-28, 1951. This congress will be participated in by the A.M.A. Council on Industrial Health, the Medical Association of Georgia and the Fulton County Medical Society. I am making plans to attend this congress and will present a supplemental report at the House of Delegates meeting in April to become a part of the foregoing.

Respectfully submitted,
G. Frederick Oetjen, *Chairman*

Dr. Payne: "The report of the Committee on Emergency Medical Service was not originally referred to Reference Committee No. 2, however, on request of the Chairman, it was referred to our committee. We have studied this report. I move its adoption."

Seconded by Dr. Marr.

Motion carried.

Report of Committee on Emergency Medical Service

James L. Borland, *Chairman*

Most of the year has been spent in organizational activities, a series of agreements being reached between the State Board of Health, the Civil Defense Organization, and the American Red Cross concerning the duties and authority of each. By a series of interlocking memberships, the various committees of the Florida Medical Association have been intergraded into the Civil Defense structure. A start has been made for a state-wide application of the Federal Defense Directive. This has to be modified to fit the individual needs of the particular community involved.

A division of the state has been made to designate vital target areas which might suffer atomic attack, those areas which would be subject to sabotage or submarine bombardment, and those which will be largely supporting areas. The medical problems are different in each. A beginning has been made, through the offices of the pharmacists, toward a uniform method of supply procurement. The next few months should see a rapid completion of a workable plan.

Respectfully submitted,
James L. Borland, *Chairman*

Dr. Payne: "Next is a resolution at the bottom of page 30 of the Handbook regarding the activities of the State Board of Health, submitted by the Indian River County Medical Society. I would like to read this resolution and then discuss our action."

Dr. Payne read the resolution.

Dr. Payne: "Your committee took the view that the State Board of Health is a bureau of the State of Florida, a legal board appointed by the

Governor; that the Florida Medical Association is a voluntary organization and as such has no jurisdiction over actions of the State Board of Health. Further, since three members of the State Board of Health are also physicians and members of our Association, we have a close tie-in, and we believe the policies of the State Board of Health are in line with the wishes of the State Association. However, in view of the fact that this resolution would put a state bureau under the jurisdiction of a voluntary organization, we felt that it was out of order. I move that we do not approve this resolution."

Motion seconded and carried.

Dr. Payne: "A resolution regarding the standardization of hospitals presented by Dr. Cook of the Jackson County Medical Society was presented and since you do not have a copy of this resolution, I think it might be wise to read it before we discuss it."

Dr. Payne read the resolution.

Dr. Payne: "Your committee was in full accord with the ideas expressed in this resolution, however, we thought that the resolution itself might be better expressed by deleting and amending certain phrases, and we have amended and deleted as follows: That in the last paragraph, the second line reading 'the organization representative of all doctors' be deleted and that in the same paragraph, line 4 reading 'professional practice in' be deleted; also, 'and that its committee for this purpose include specialists, general practice men and educators' be deleted. The last paragraph, as amended, follows: 'THEREFORE THEN, BE IT RESOLVED: That the House of Delegates of the Florida Medical Association affirm a stand that the American Medical Association assume the full responsibility for the standardization of hospitals, and that this body instruct its delegates to the Atlantic City Meeting in June 1951 of the American Medical Association to bring their efforts to bear in behalf of this program.' I move for adoption as amended."

Seconded by Dr. Herz.

Motion carried.

Resolution

WHEREAS, there is a movement afoot to transfer the function of standardizing hospitals from the American College of Surgeons to the American Hospital Association, and,

WHEREAS, this is so without consultation with the American Medical Association, and,

WHEREAS, The American Hospital Association is a lay body not bound by the traditions of American medicine, and

WHEREAS, such a move could be a deadly blow to the medical control of hospitals,

THEREFORE THEN, BE IT RESOLVED: That the House of Delegates of the Florida Medical Association affirm a stand that the American Medical Association assume the full responsibility for the standardization of hospitals, and that this body instruct its delegates to the Atlantic City Meeting in June 1951 of the American Medical Association to bring their efforts to bear in behalf of this program.

Respectfully submitted,
Jackson County Medical Society
James T. Cook, *Delegate*

Dr. Payne: "This is the report on a resolution on the Appointment of Qualified Pathologists to Serve as Medical Examiners, presented by the Dade County Medical Association, and signed by Dr. Jack Q. Cleveland, President. This is a short resolution and I would like to read it to you."

Dr. Payne read the resolution.

Dr. Payne: "It was the consensus after this discussion that there is a decided need for some change that would bring our antiquated laws up to date. It would be impossible, at this late date, to have a bill drawn up and introduced into the Legislature during the present session. We also feel that this resolution does not cover adequately the problem and that we should refer this back to the incoming president of this Association with a request that he appoint a special committee, or refer it to an existing standing committee to make a complete study of this problem, and to make a report and recommendation to a meeting of the House of Delegates at our next Annual Meeting. By so doing, it could be acted on and could be handled by our Legislative Committee and our recommendations sent to the Legislature in time for passage. We feel that our present laws are inadequate. There has been a great deal written on this subject, and the A.M.A. has taken a stand on it. Many states are studying this problem and we should have the benefit of all the studies of other states where this problem is being worked out. I move that these recommendations be adopted."

Seconded by Dr. Rutter.

Motion carried.

Resolution

BE IT RESOLVED BY THE FLORIDA MEDICAL ASSOCIATION: That it would look with favor on legislation which would provide for the appointment of qualified pathologists to serve as medical examiners, who would make examinations of all persons dying from unnatural causes in lieu of the present system.

Respectfully submitted,
Dade County Medical Association
Jack Q. Cleveland, President

Unanimously passed at the regular monthly meeting this 3rd day of April, 1951, for submission to the FMA House of Delegates.

Report of Reference Committee No. 3

Dr. Shaler Richardson, Chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the recommendations of that committee.

Dr. Richardson: "The report of the Board of Governors was approved as presented. I move its adoption."

Seconded by Dr. Herpel.

Motion carried.

Report of Board of Governors

Herbert E. White, *Chairman*

Three meetings of the Board of Governors were held as follows: April 26, 1950, August 26, 1950 and January 14, 1951. At the last meeting of the Board, every member was present. This is an indication of the faithfulness to duty of those who are serving you on this Board.

The dates for the Seventy-Seventh Annual Meeting of the Association at Hollywood were set for April 23-25, 1951.

An operating budget for the fiscal year beginning April 1950 was presented by Dr. Robert B. McIver, Secretary, and approved.

The schedule to be followed at the Seventy-Seventh Annual Meeting was discussed in detail and approved.

A pamphlet by Dr. Louis M. Orr, II, entitled, "Legal Aspects of Doctors' Political Activities" was edited and reprinted by Whitaker-Baxter under the caption, "Doctors Are Citizens." It was so highly thought of by Whitaker-Baxter that they had 200,000 copies printed and sent to every state medical society for distribution. The Board approved imprinting at the end of this pamphlet, "Board of Governors, Florida Medical Association, Jacksonville 1, Florida."

The following members, on recommendation of their local county medical societies were elected to Honorary Membership: Drs. Robert L. Hughes, James B. Lowry, W. McL. Shaw, Robt. D. Sistrunk, Roy E. Wilhoite, Banks H. Goodale, Winston F. Harrison, Genald J. Walsh, Harrison A. Walker, Thomas O. Otto, Louise DeVore, Hamilton B. Frobisher, Wm. W. Kirk, Daniel H. Mathers, Frank B. Voris, Nelson M. Black, Charles S. Early, Eston D. White, Evans B. Wood, Clifford C. Woods, LeRoy A. Wylie, Ellis W. Holloway, W. Henry Spiers.

At the request of the Board, the Monroe County Medical Society By-Laws were amended to delete, "a member to be in good standing must be engaged in active practice of medicine in Monroe County at least 10 months out of the year unless engaged in postgraduate study or for any other reasonable, acceptable excuse."

The Board approved the rental of a technical exhibit booth to the Professional Insurance Corporation at the Annual Convention.

Approval was authorized to pay for one membership in the State Chamber of Commerce.

Authorization was granted for a "Committee on Medicine and Hospitals" with representation from the Florida Medical Association, Blue Shield-Blue Cross, and the Florida Hospital Association to proceed on basically the same plan as in 1949 in connection with the legislative program.

After careful consideration and discussion, the Board went on record as disapproving the creation of a speaker and vice speaker of the House of Delegates at the present time as it feels that the State Association is not large enough to warrant a speaker of the House and also would deny the president the privilege of presiding. It was recommended that the president be encouraged to appoint for himself a parliamentarian.

The president was authorized to designate the time and place of a joint meeting of the Board of Governors, members of the House of Delegates, Bureau of Public Relations, and the Committee on Legislation and Public Policy, which was designated at the last meeting of the House of Delegates to be called sixty (60) days before the convening of the Legislature for the purpose of planning a definite legislative program. (June Journal, page 756). President White designated January 28, 1951 as the date and the place as Ocala.

Dr. Frazier J. Payton, Chairman of the Association's Committee on Cancer Control read a report recommending a coordinating cancer control committee to be known as "Florida Cancer Council" to avoid over-lapping of activities of the State Board of Health, Florida Medical Association and the Florida Division of the American Cancer Society. The Board gave its approval pending action of the House of Delegates. Complete details will appear in the annual report of the Association's Committee on Cancer Control published in this Handbook for Members of the House of Delegates and referred to Reference Committee 1, Health and Education.

The Board recommends that the By-Laws be amended to excuse certain members from the payment of dues because of advanced age or who are physically disabled provided such payment would constitute a financial hardship. Example: One member is nearly 90 years of age, must practice a little for financial reasons, cannot pay current dues: a similar case, a member who is 77 years of age.

Recommended amendment to Chapter VIII, Section 1, paragraph (90) By-Laws to include the following:

An active member may be excused from the payment of dues when it is deemed advisable by the Board of Governors, provided such payment would constitute a financial hardship as determined by his county medical society. The following members whose practices are partially or temporarily interrupted may be excused in accordance with this provision: active members of advanced age or physically disabled.

Your Board recommends the tabling of Resolution on "Associate Members" (June Journal, page 762) which was referred back to the Board of Governors.

Dr. McIver, secretary, reported that Stewart G. Thompson upon his attaining the age of 70 years, (May 27, 1951) * * * shall receive from the Retirement Fund set up \$300.00 per month as long as he shall live. (June 1947 Journal, page 714.) "That should the Association desire to retain the services of Dr. Thompson after he becomes 70 years of age and he being agreeable thereto, it may enter into special year to year agreements with him but that same shall in no wise alter or impair his right to receive the aforesaid life income." The Board notified Dr. Thompson that his services were desired for the coming year in the same capacity and a committee was appointed to go into all phases with Dr. Thompson and report at the post-convention Board meeting, April 25, 1951.

The Board recommends that no action be taken on a Resolution concerning "Doctors appearing before legislative committee to be briefed, etc." (June Journal, page 759.)

Your Board recommends that no positive action be taken on Resolution, "Doctors not licensed who receive remuneration for professional services." (June Journal, pages 759-760.) Comment: Proposed changes in the Medical Practice Act will be taken up at this year's session of the Legislature.

Sub-Committee to Board of Governors on Review of Fee Schedules

The Sub-Committee to the Board of Governors on Review of Fee Schedules, which was named in November 1950, has had two meetings and considerable progress has been made. The first project that the Committee agreed upon, was to revamp and make a unified Fee Schedule for all Federally subsidized agencies. The Committee is approaching the subject in a very democratic way, namely, the general practitioner and each particular specialty represented on the Committee, is to get an expression from each and every member as to the proper and just fee for each particular procedure.

The subject of Industrial Commission Fee Schedule and the Schedule of the Blue Shield cannot be taken up at this time due to a lack of time.

It is very gratifying to observe the great amount of interest that is being shown. I wish to take this opportunity to thank the members of my Committee in co-operating to the fullest in getting the initial work done to this date.

John D. Milton, *Chairman*

**Sub-Committee to Board of Governors
on Veterans Care**

I wish to report that during the year 1950 the Veterans Administration in the state of Florida paid to members of the Florida Medical Association \$231,875.32 for the examination and treatment of 18,175 veterans.

Frederick H. Bowen, *Chairman*

**Sub-Committee to Board of Governors
on Liaison-National Foundation Infantile Paralysis**

There is nothing to report of interest from this committee.

Frederick H. Bowen, *Chairman*

**Sub-Committee to Board of Governors
on Blue Shield**

During 1950 the Florida Blue Shield Plan progressed steadily in all phases of its operations. There was an enrolment gain of 53,281 members during the year, bringing total enrolment as of Dec. 31, 1950, to 203,783.

The Plan's gross income during 1950 was \$1,720,655.78, of which \$1,274,085.46, or 74 per cent, was paid to physicians for 26,650 cases, and \$50,902.70 was accrued for unreported cases and cases reported but unpaid.

Operating expenses amounted to 14.6 per cent of income. The net income added to reserve during 1950 amounted to \$147,134.55, or 8.5 per cent of the Plan's gross income.

Leigh F. Robinson, *Chairman*

Recommended that the Hollywood Beach Hotel in Hollywood be designated as the meeting place for the 1952 annual meeting. The By-Laws provide that the dates for the meeting shall be set by the Board of Governors.

* * *

Recommended amendment to Chapter VIII, Section 1, paragraph (90) By-Laws to include the following:

An active member may be excused from the payment of dues when it is deemed advisable by the Board of Governors, provided such payment would constitute a financial hardship as determined by his county medical society. The following members whose practices are partially or temporarily interrupted may be excused in accordance with this provision: active members of advanced age or physically disabled.

Respectfully submitted,
Herbert E. White, *Chairman*

Dr. Richardson: "The report of the Committee on Interrelationship was approved as published in the Handbook with the following amendment: That the part of the report of the Committee on Interrelationship pertaining to the subscription of \$500.00 to support the Bureau of Professional Relations, University of Florida be disapproved but that it be given further study by the Board of Governors. I move the adoption of the report as published with the amendment I have just read."

Seconded by Dr. Stebbins.

Motion carried.

Report of Committee on Interrelationship

Henry J. Peavy, *Chairman*

Only routine activities have concerned your Committee on Interrelationship. There is a marked increase in communications between this committee and similar ones of the Florida Dental Association and Florida Pharmaceutical Association.

The last meeting of the Florida Medical Association voted an annual subscription of five hundred dollars (\$500.00) to support the Bureau of Professional Relations, University of Florida, if the money is available.

Your committee suggests this subscription be available this year.

Respectfully submitted,
Henry J. Peavy, *Chairman*

Dr. Richardson: "The report of the Committee on Necrology is received as information and I wish to read the list of members of this society who have passed on since our last meeting. I move that this report be approved and that the members of this body stand for a moment in silent respect to those who have passed on since our last meeting."

Motion seconded and carried.

Report of Committee on Necrology

Joseph Halton, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Starling P. Alderson, Miami
Warren E. Anderson, Pensacola
William F. Bay, Bradenton
John A. Beals, Jacksonville
William D. Brinson, Baldwin
Paul T. Butler, Orlando
Leland F. Carlton, Tampa
Miriam M. Drane, St. Petersburg
Reuel A. Ely, Tampa
James H. Fellows, Pensacola
Elmo D. French, Miami
Robert F. Godard, Quincy
Lester W. Horne, St. Petersburg
Geo. C. Johnston, Orlando
Wilson M. Lancaster, Orlando
Leon S. Lippincott, Daytona Beach
Wm. W. Massey, Quincy
Paul O. Messner, Miami Springs
Dick D. Nave, Hialeah
Samuel R. Norris, Jacksonville
Henry B. Oertel, Kissimmee
G. Walter Potter, St. Augustine
Elsmere R. Rickard, Tampa
Ralph E. Russell, Ocala
Edwin C. Swift, Jacksonville
J. Ralph Vallotton, Daytona Beach
Jos. P. Williamson, Winter Park

Supplement

John T. Bowen, Clearwater
James L. Estes, Tampa
John T. Macdonald, Miami
Manuel A. Perez, Tampa
Gideon Timberlake, St. Petersburg

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
Joseph Halton, *Chairman*

Dr. Richardson: "The report of the Committee on Councilor Districts and Council was approved as printed in the Handbook. It is recommended that Chapter XI, Section 6, paragraph (102) of the By-Laws which reads 'Any physician who may feel aggrieved by the action of the society of his county in refusing him membership or in suspending or expelling him shall have the right to appeal to the Council which, upon a majority vote, may permit him to become a member of an adjacent county society,' be referred to the Board of Governors for further study and consideration. There are many angles to this suggested change in the By-Laws and certainly it should be given very thorough and careful study before positive action is taken upon it. I move the adoption of this report as amended."

Seconded by Dr. Bartlett.

Motion carried.

Report of Council

Lloyd J. Netto, *Chairman*

One of the major activities of the Council is arranging Fall Meetings in the four medical districts. The first meeting was held in Marianna on October 30, 1950; the second in Ocala on November 1; the third at Fort Myers on November 2; and the fourth at West Palm Beach on November 3. Two scientific papers were presented at each of the four meetings as well as short addresses by the Association officers.

One innovation from the usual procedure was to schedule the Chairman of the Association's Committee on Legislation and Public Policy immediately following the dinner in the evening. This procedure provided sufficient time for the speaker to cover his subject and also gave an opportunity for the doctors' wives to hear the address which was of particular interest to them since they have been very active during the past year in education and public relations. The consensus of those present was to the effect that the experiment of having the presentation following the dinner was very much worthwhile.

The complete program and write-up on the meetings may be found in the October 1950 Journal, so the information will not be repeated in this report for reasons of brevity.

As Chairman of the Council, I received a complaint from Luther T. Pennington, M.D., of Melbourne objecting to his suspension from the Brevard County Medical Society. The action of the society is as follows:

"At the regular meeting of the Brevard County Medical Society in Cocoa, December 13, 1948, a recommendation was made by the Board of Censors after due investigation of charges, that Dr. L. T. Pennington of Melbourne be suspended from the society. Acceptance of the recommendation as given was made by unanimous vote of the society members."

To avoid the expense of calling a meeting of the Council for a hearing, I made a trip to Melbourne in order to glean the facts as far as possible, made numerous long distance telephone calls and wrote a number of letters.

Dr. Cleland D. Cochrane of Daytona Beach, Councilor for the Fourth District, made two personal trips and spent one whole day in Melbourne conferring with local doctors and others in connection with the questions involved.

The members of the Council voted by mail:

"To permit Dr. Luther T. Pennington to make application for membership in the Orange County Medical

Society provided he will drop his demand for a hearing by the Council in connection with his suspension by the Brevard County Medical Society."

Dr. Pennington has not paid his state dues since 1948, so he is not a member of the Florida Medical Association. On September 29, 1950, Dr. Pennington signed a communication which was addressed to me as Chairman of the Council which reads in part:

"In view of the Council of the Florida Medical Association's approving my making application for membership in the Orange County Medical Society, I hereby withdraw my appeal for a hearing before the Council on charges against me by the Brevard County Medical Society, December 1948, in accordance with the suggestion contained in your letter to me of September 28, 1950."

Chapter XI, Section 6, paragraph (102) of the By-Laws reads:

"Any physician who may feel aggrieved by the action of the society of his county in refusing him membership or in suspending or expelling him, shall have the right of appeal to the Council which, upon a majority vote, may permit him to become a member of an adjacent county society."

This section of the By-Laws is interpreted to mean that a suspended member by one county medical society may have the privilege of applying for membership in another county medical society provided the Council permits. Since Section 5, paragraph (101) specifies that each county medical society shall judge the qualifications of its own members, etc., therefore, it is assumed that whether or not another county medical society will or will not accept Dr. Luther T. Pennington as a member, is not the responsibility of the Council and we, therefore, consider the matter closed.

Respectfully submitted,
Lloyd J. Netto, *Chairman*

Dr. Richardson: "The report of the Committee on Advisory to Woman's Auxiliary together with the supplemental report is approved with an expression of appreciation to the Woman's Auxiliary for the good work they did in the past year. I move adoption of this report."

Seconded by Dr. Herz.

Motion Carried.

Report of Committee on Advisory to Woman's Auxiliary

James L. Anderson, *Chairman*

Your Medical Advisory Committee felt that certain questions of policy should represent the attitude of the Florida Medical Association rather than one individual's opinion. Accordingly, questions regarding expansion of the number of auxiliaries, their aims and purposes were cleared with the Florida Medical Association and then discussed in detail with auxiliary board members at a meeting which was held in Quincy, Florida, on Oct. 6, 1950. Since that time, two new auxiliaries have been organized. We are stressing coordination of effort with the Florida Medical Association in obtaining better health education. A committee has been appointed for revision of constitution and by-laws in accordance with a request of the national organization. An auxiliary for every medical society in the state remains our goal.

Supplement

The Chairman of the Auxiliary Advisory Board of the Woman's Auxiliary reports three new county auxiliaries organized during the past year. The Auxiliary is represented on all national health drives, approved by the state advisory committee. Two cash prizes totaling \$55 were awarded to the Auxiliaries of Escambia and Duval as the

result of the sale of "Today's Health." The Auxiliary has issued three numbers of its first periodical "The Medaux" to all doctors' wives in the state. A nurses' scholarship loan fund of \$1,000 is available for use by the county auxiliaries on the matching fund basis. Action was taken to endorse resolutions concerning mental health and the nurses' mandatory act legislation if such recommendation is made by the Florida Medical Association. There is excellent rapport between the Advisory Committee of the Florida Medical Association and the Auxiliary to the Florida Medical Association.

Respectfully submitted,
James L. Anderson, *Chairman*

Dr. Richardson: "Next is the report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists with supplemental report, Dr. J. Rocher Chappell, Chairman. This report is approved with a supplement to the supplemental report: that in the event any communication directed from the Florida Medical Advisory Committee to Selective Service for Physicians and Allied Specialists is sent to military authorities regarding the essentiality or availability of any physician belonging to the Florida Medical Association, a copy of this information will be sent to the State Medical Association headquarters and to the county medical society of each physician involved. I move adoption of this report as amended."

Seconded by Dr. Herpel.

Motion carried.

Report of Committee On Advisory to Selective Service for Physicians and Allied Specialists

J. Rocher Chappell, *Chairman*

On August 8, 1950, President Herbert E. White appointed the following committee for the procurement and assignment of doctors of medicine to military service in the State of Florida: J. Rocher Chappell of Orlando, chairman; Donald W. Smith of Miami, John E. Maines, Jr., of Gainesville, Alvin L. Mills of St. Petersburg and Thomas H. Bates of Lake City. President White also requested the president of each county society to appoint a local committee. The chairman of this committee called an organizational meeting in Ponte Vedra on Aug. 22, 1950. All of the committee members were present.

The functions of the committee were discussed generally and not knowing how men were to be called into the service (this was before Public Law No. 779 was passed by the Congress) we accepted and adopted a point system for the calling of doctors into military service. A questionnaire was made out and a point evaluation system was adopted. These questionnaires were mailed to each member of the county medical society and to M.D.'s practicing in the county who were not members of the county medical society. The questionnaires were collected by the local county committees, tabulated and mailed to the Association office in Jacksonville where a copy was made of each. The original was mailed to me and the copy filed in the Association office. At this point I would like to express our appreciation to Dr. Stewart Thompson and his staff for their cooperation and service given to this committee. Without them we could never have functioned properly.

Shortly after the state committee was formed, your chairman received a telegram from Howard A. Rusk, M.D., chairman of the National Advisory Committee to Selective Service in Washington, asking him to accept the

chairmanship of the Florida Volunteer Advisory Committee to Selective Service for Physicians, Dentists, Veterinarians and Allied Specialists. Your chairman accepted this additional job. Appointed with him were Wilson T. Sowder, M.D., of Jacksonville, and Fred O. Conrad, D.D.S., of Tallahassee.

Shortly thereafter on Oct. 22, 1950, a meeting was called of all similar committees of the Florida Medical Association, Florida Dental Association, and the Florida Veterinary Association, to be held in Orlando. Little was known then concerning the method of taking men into military service. However, Public Law No. 779 had been passed by the Congress and the registration date had been set for October 16 for those men in priorities I and II. The meeting in Orlando was well attended by all the committees and considerable information was gained both by local and state committees. General problems were discussed and answered as accurately as possible. Col. Robert G. White and Lt. Col. Harold Wahl of the Selective Service System headquarters in St. Augustine were present and answered many questions concerning the draft.

The Florida Volunteer Advisory Committee to Selective Service for Doctors, Dentists, Veterinarians and Allied Specialists, felt that it needed the advice of a veterinarian and elected D. A. Sanders, D.V.M., president of the Florida State Veterinary Association, as a fourth member of their committee. On January 12 and 13 this committee was called to Washington for the purpose of meeting with the National Advisory Committee, Selective Service officials and others. Considerable information was gained at that time which was relayed to the local county committees at a meeting held in Jacksonville on Feb. 18, 1951.

The Florida Volunteer Advisory Committee to Selective Service feels that the name of the Florida Medical Association Committee should be changed from the Florida Medical Association Committee for the Procurement and Assignment of Physicians, to Advisory Committee to Selective Service for Physicians and Allied Specialists. (President Herbert E. White officially changed the name Feb. 8, 1951). It is necessary that the Florida Medical Association Committee take on the Allied Specialists, as we were informed in Washington that soon nurses would come under our jurisdiction and we already have X-ray Servicemen and Orthopedic and Prosthetic Appliance Men, and have been asked to render advice to Selective Service concerning them. It is expected that in the future pharmacists, osteopaths, laboratory and X-ray technicians will also come under the jurisdiction of these committees. Physicians have more local committees in the state than do the dentists or veterinarians; therefore, it is felt that physicians should be the logical ones to handle these requests.

On behalf of the Florida Medical Association committee, I would like to thank the members of the local county medical society committees for their untiring work and ready response to calls which have been made upon them for information and service. Theirs is a difficult task and they have responded most generously on each occasion.

Supplement

Since submitting our original report which is published in the handbook, your committee has received some figures on physicians subject to registration under Public Law No. 779. We would like to submit these figures for your information:

Under the Special Registration No. 1 held October 16, 1950, 174 physicians in the state of Florida registered. Of these 133 were in priority I, and 41 were in priority II.

Under Special Registration No. 1 held January 15, 1951, there were a total of 1,129 physicians in the state of Florida who registered. Of these 403 were in priority III and 726 were in priority IV.

Since Public Law No. 779 began operating, 23 physicians in the state of Florida have accepted commissions and have been nominated for call to active duty through May, 1951. Seventeen physicians have accepted commissions but have not been nominated for call to active duty.

You will probably be interested to know that your committee deferred 39 physicians for occupational reasons. There were two physicians deferred for dependency reasons, this was done by the military. There were 25 physicians rejected because of physical disabilities.

It is interesting to note that 18 physicians who registered in Florida for the draft stated that they would not accept a commission and 7 who did indicate a desire for commission have since declined the appointment tendered. These physicians are in priority I, and it means that there are 25 physicians practicing in the state of Florida who received a part or all of their education at government expense and have refused commissions in the military service.

Since submitting our original report your committee, on April 1, this year, took under their jurisdiction the availability clearance of Reserve Officers into the military service.

There are approximately 138 Army Medical Corps Reserve Officers in the active reserve and 68 in the inactive reserve in this state. There are 32 Air Force Medical Reserve Officers in Florida as of this date. Information as to the number of Naval Medical Reserve Officers has been requested but not obtained.

Your committee would like to express their sincere appreciation to the County Advisory Committees. They have been most responsive and have cooperated in every manner possible, and we have only the highest praise for their activities.

We would like to express our appreciation to the Third Army headquarters, Fort McPherson, Georgia; the 14th Air Force Headquarters, Warner Robbins Field, Georgia; and to the Commandant, Sixth Naval District Headquarters, Charleston, South Carolina. The cooperation received from these three branches of military service has been most satisfactory.

In conclusion, we would like to express our appreciation to the State Selective Service Boards for their willingness and desire to cooperate with our committee on all occasions. It can be said here that not one single request made by the Advisory Committee to local Selective Service Boards has been refused.

We would like this expression of appreciation to be sent to the State Selective Service System and to the Commanding Officers of the three military services from the officials of the Florida Medical Association.

In the event any communication directed from the Florida Medical Advisory Committee to Selective Service for Physicians and Allied Specialists is sent to military authorities regarding the essentiality or availability of any physician belonging to the Florida Medical Association, a copy of this information will be sent to the State Medical Association headquarters and to the county medical society of each physician involved.

Respectfully submitted,
J. Rocher Chappell, *Chairman*

Dr. Richardson: "Regarding the resolution to change our By-Laws in regard to the time and place of the presidential address which comes from the Dade County Medical Association, which was read yesterday. If I may sum up briefly the intent of the resolution, it is that the presidential address be read before the House of Delegates instead of the General Session and also that the reports of the Secretary-Treasurer and the Editor of The Journal be published rather than being read. The committee gave careful consideration to these changes in the By-Laws and felt that they should be approved and that the changes should be made. The presidential addresses are frequently read to too small audiences and certainly the House of Dele-

gates affords a better audience for the presidential address. As you all know, this does not exclude any members of the Association because the House of Delegates is open to all members of the Association. Insofar as changing the By-Laws that would merely do away with the reading of the Secretary-Treasurer's report and the Editor's report, the committee feels that this is also a good thing. These reports are published in The Journal and if anyone desires to study them, they will want to read them rather than hear them read. Then too, this will save considerable time. Therefore, the committee wishes to recommend the approval of the changes in the By-Laws. I move approval of this resolution."

Motion seconded and carried.

Resolution

WHEREAS, Since the annual address of the President usually reviews the activities of the Association for the past year and contains the recommendations of the President for the future, it is of importance to the Delegates; therefore, in order to insure a full attendance of the Delegates at the address of the President BE IT HEREBY RESOLVED:

1. That the By-Laws be changed as follows:

- A. Chapter II, Section 1 in the line which reads, "Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President" be changed by striking the words "the annual address of the President, and."
- B. Chapter III, Section 1—That the line which reads, "or with the session held for the address of the President and the annual oration," shall be changed by eliminating "address of the President and" so that the line will finally read "or with the session held for the annual oration."
- C. At the end of Chapter III, Section 1, Paragraph 32, entitled, "House of Delegates" be added the line "The President shall deliver his address at a meeting of the House of Delegates each year."
- D. Chapter V, Section 3, Paragraph 58, entitled, "Treasurer," that the line which reads "and render an annual report of his doings to a General Session of the Association" shall be changed to read, "and render a written report of his doings for publication in The Journal."
- E. Chapter V, Section 4, Paragraph 59, entitled, "Secretary," that the line which reads, "He shall annually make a report of his doings to a General Session of the Association" be changed to "He shall annually furnish a written report for publication in The Journal."

Respectfully submitted,
Dade County Medical Association
Jack Q. Cleveland, *President*

Dr. Richardson: "The resolution on presenting a Certificate of Honor to Dr. Stewart G. Thompson, presented by Dr. Jelks is approved. I move its adoption."

Seconded by Dr. Herz.

Motion carried.

Resolution

WHEREAS, Dr. Stewart Thompson, during an uninterrupted period of twenty-five years, has rendered invaluable service to the Florida Medical Association, unparalleled in its history, and

WHEREAS, Dr. Thompson's devoted service has been largely responsible for outstanding progress of the Association during that period,

BE IT THEREFORE RESOLVED, That the House of Delegates hereby requests and authorizes the Board of Governors to present Dr. Thompson a "Certificate of Honor" commemorating a quarter century of unselfish and outstanding service.

Dr. White: "I would like to thank the members of the three reference committees for their work. I am sure the delegates realize that they have spent much time and rendered us a great service on these reports."

Dr. White: "If there is no other business to come before the House of Delegates, we will now have the election of officers. Nominations are now in order for the office of President-elect."

Dr. Orr: "This is a nomination that I take great pleasure in making and calls for no nominating speech whatsoever. I want to place in nomination the name of a man who has done as much or more over the years for this organization as any other member, and who will do more in the future. I nominate Dr. Robert B. McIver for the consideration of this body."

Dr. McLane: "In view of our appreciation of Dr. McIver's services, I move that nominations be closed and the secretary cast the ballot for Dr. McIver."

Seconded by Dr. Langley.

Motion carried.

The Chair declared Dr. McIver the President-elect.

Dr. McIver: "Of course, I had the idea that I might be nominated. I talked it over with Eddie, our yard man, who has been in our family for about 40 years and Miss Ida had told him that I might get nominated, so Eddie congratulated me. I told him I hadn't been nominated yet, and what did he think about my chances, and he said he would take it up with Uncle Henry. Now, when the lawn mower won't work or anything goes wrong, Eddie takes it up with Uncle Henry — and Uncle Henry has been dead for 30 years. Later Eddie told me, 'you don't want to write no speech, it's bad luck, you might not get nominated.'"

"In all of my efforts, I have had two backers. The biggest and best has been at home and I would like to ask Miss Ida to stand. Now, as a slight token of my deep appreciation and affection for Stewart Thompson —"

Dr. McIver presented Dr. Thompson with a silver salver engraved as follows:

*Stewart G. Thompson
Florida Medical Association
Gentleman Churchman Scholar Executive
Golfer Pipe Smoker and Loyal Friend
Whose Services And Courtesies
Are Acknowledged
Robert B. McIver
April 1951*

Dr. White: "Nominations are now in order for first vice president."

Dr. Herz: "I nominate for the office of first vice president, Dr. Edward R. Annis of Miami."

Dr. White: "Are there any other nominations?"

Dr. Hibbs: "I would like to nominate Dr. Frederick K. Herpel."

Dr. Annis: "I sincerely appreciate the nomination given to me by the gentleman from Key West. This is the first opportunity I have had to serve as a delegate from a county society. I would like to withdraw my name for consideration as first vice-president until such time as I have been a member of this organization and a participant in its affairs for some years so I can be properly educated."

Dr. White: "Are there any other nominations?"

Dr. Rutter: "I move that nominations be closed, and the secretary cast the ballot for Dr. Herpel."

Motion seconded and carried.

The Chair declared Dr. Herpel the first vice-president.

Dr. Herpel: "I think anyone who is nominated to the office of first vice-president has the definite feeling that he may be called upon to assume more than is shown on the surface. I appreciate the honor, but I think there may be some question as to which one goes back into the Army first. By length of service in two World Wars, I assume that our president, who comes in today, is a little bit ahead of me. As first vice-president, I will study the operation of this office so if I am called upon to assume this office, I will try to discharge it to the best of my ability and to your satisfaction."

Dr. White: "Nominations are now in order for second vice-president."

Dr. Chas. J. Collins of Orlando was nominated for second vice-president. Motion made and seconded that nominations be closed and the secretary cast the ballot for Dr. Collins.

Motion carried.

The Chair declared Dr. Collins the second vice-president.

Dr. White: "Nominations are now in order for third vice-president."

Dr. Pearson: "I believe we have gotten down to the place now where probably Ed Annis could serve in that office."

Dr. Kenaston: "I move that nominations be closed and the secretary cast the ballot for Dr. Annis."

Seconded by Dr. Stebbins.

Motion carried.

Dr. White: "Nominations are now in order for the office of secretary-treasurer."

Dr. Jere W. Annis: "Since we have just lost a good one, it seems to me that we have quite a job in selecting a new secretary and treasurer. In the first place we are electing the wheel-horse of the organization and if we follow precedent, it should be someone who could serve for the next ten or fifteen years, depending on how his health holds out. In the second place, we must consider the advisability, and it is strictly from my point of view, of selecting an individual who while he may not be able to board and room with Mr. FMA, Dr. Thompson, of course, that is what we would like but Mrs. Thompson might object, he should be where Stewart could tell him what to do just as he has with Bob. It also seems to be advisable, since Bob will be very active in this Association for the next two years, that he also should have the opportunity of instructing the new secretary, and of working with him as closely as possible.

"In addition to that, we have an organization which spends some \$100,000 a year and as one of the stock holders, I would like to see the man who is responsible for carrying out the policies and signing the checks in a position where he could go to the office. I think we should have a man from Jacksonville unless we propose moving the state office. With that in mind, I would like to propose for your consideration, Dr. Sam Day of Jacksonville. I propose him because he has all of these qualifications, because he would make a good secretary, and because he has the qualification of proximity to the two men who will be guiding the

destinies of this organization. Again I would like to nominate Dr. Sam Day as secretary-treasurer of this Association."

Dr. White: "Dr. Day has been nominated for the office of secretary and treasurer; are there any other nominations?"

Dr. Jelks: "The delegation from Jacksonville asked me to say something about Dr. Day for your information and just why he was nominated. Anticipating that this vacancy in our office of secretary-treasurer might occur, the Duval County Medical Society considered the possible candidates to present to you provided you want to follow the suggestions made by Dr. Annis. Very carefully the society considered what available candidates we might have to present to you. Dr. Day is a young man in the community and young in years, he is 36, but we have lived with him long enough to appreciate his qualities which we think would fit into the job. He is active in civic affairs, he recently was our secretary and was one of the best we have ever had. We want you to do what you care to in this situation but as a matter of helping you decide, we did want to present Dr. Day and to tell you why we did it. I second the nomination."

Dr. White: "Are there any other nominations?"

Dr. Bartlett moved that nominations be closed and that the secretary cast the ballot for Dr. Day.

Seconded by Dr. McLane.

Motion carried.

The Chair declared Dr. Samuel M. Day the secretary-treasurer.

Dr. White: "Nominations are in order for editor of The Journal."

Dr. McEwan: "This sounds like an all Jacksonville delegation, but I don't see what we can do about it. I nominate Dr. Shaler Richardson."

Dr. Richards moved that nominations be closed and the secretary cast the ballot for Dr. Richardson.

Motion seconded and carried.

The Chair declared Dr. Richardson the editor of The Journal.

Dr. White: "Under the report of the Board of Governors, I would like to call your attention to one recommendation, and that is that our Seventy-Eighth Annual Meeting of the Florida Medical Association be held at the Hollywood Beach Hotel."

No action was required.

Dr. Payne: "I rise to a point of order. For some time I have been working on a speech to nominate our distinguished secretary-treasurer for president-elect of this Association. Our Constitution says that the election shall be held at noon and with that in mind I stepped out and came back in at five minutes before twelve, and find that it is all over. Now I maintain that all elections held before twelve o'clock should be held illegal so that I should be permitted to make my nominating speech that I have been working so hard on."

Dr. Pearson: "I would like to rise also to a point of order, and if Dr. Payne had made a motion, I would have seconded it. I realize that we have had a very excellent president over the last year, but I do question his ability to set himself up as Joshua and command the sun to stand still. He said that it was 12:00 o'clock according to his watch but I will cite you the Constitution where it says nothing about 12:00 o'clock, it says noon, so I believe Dr. Payne is entirely in order. This election has run off with surprising smoothness, and since it is now noon according to my watch, I make a motion that the action of this House which has been taken in the last 20 minutes be declared legal."

Motion seconded and carried.

Dr. White: "At this time, it gives me a great deal of pleasure to appoint a committee, Dr. Rowlett and Dr. Patterson, to escort our new president, Dr. David R. Murphey, to the rostrum."

DR. MURPHEY: Mr. Past President, Officers, Members of the Florida Medical Association, Members of the Woman's Auxiliary and Guests.

I assure you that I accept the honor which you have bestowed on me with humility, especially when I look over the long list of distinguished physicians who have preceded me in this office. I am deeply grateful. This is a proud and happy day in my life. I want to thank those who had so much confidence in me and worked so diligently to give me this honor.

The responsibilities which I am assuming are appalling and I am fully conscious of the magnitude of my job. I appeal to each of you for your cooperation and assistance in this task. In turn, I will do my best to continue the administration of the affairs of this great medical association on its previous high plane, with all of my energy and to the best of my ability.

One year ago, the state of Florida was engaged in a great political struggle, the outcome of which was international in scope and would affect not only our generation but generations to come. Led by the Florida Doctors of Medicine, free enterprise in America was preserved and the forces of socialism temporarily turned back. This victory represents the greatest contribution to American medicine ever made by our State. It demonstrated the inherent political power of our profession, heretofore untied. The outcome of this struggle, the first in which the issue was so clearly drawn, was watched throughout the nation and gave courage to those yet to meet the same challenge.

On every political front, the American way of life prevailed and it is generally conceded throughout the nation that the results in Florida had a profound influence on the re-election of medicine's most outspoken defender in the United States Senate, the Honorable Robert Taft of Ohio.

We must not forget that we were so ably assisted by our wives who daily share the successes and heartaches associated with our professional careers. These ladies worked day in and day out during the long and arduous campaign, and without their help it is doubtful if it would have succeeded. Ladies, on behalf of the Florida Medical Association, I thank you.

We must remember the fight is not over. The victory is only temporary. Nor must we lose sight of our true antagonist—complete socialism, not one of its tentacles, socialized medicine. It is a well known historical fact that national socialization must be preceded by socialization of medicine. For this reason, we found many allies in our recent struggle. Our profession is the first line of defense in preserving free enterprise in America. We must be equal to the task.

We are living in a changing world. These are tumultuous times. The day is passed when one can sit back and quietly enjoy a status quo. The public has many justifiable complaints against our present system. The profession must find a solution to these problems if we are to survive. It is not sufficient to say that America is the healthiest nation on earth nor that the present system of dispensing medical care in this country the best developed.

In addition, governmental agencies are not the sole threat to the free and independent practice of medicine. Many lay groups, variously organized and motivated, constantly plant socialistic acorns from which mighty socialistic oaks grow. A division of the profession and socialization of any of its component parts must be zealously guarded against lest we find ourselves insidiously taken over.

An analysis of the recent election returns reveals that the issue was largely decided in the smaller counties and communities and not in the large urban areas. It must be remembered that the political thinking of these smaller communities was influenced by factors other than socialized medicine. Our educational campaign directed by the Public Relations Committee must be expanded into rural areas. The entire membership of the Florida Medical Association must become members of our Public Relations Committee. Each individual member of the profession must become public relations conscious lest he damage our cause by some inadvertent, thoughtless act.

The year 1951 finds our nation dangerously close to a declared war. More of our members will be called into the service of our country. The disproportion between our rapidly growing civilian population and the medical population will be increased, making it increasingly difficult to furnish medical care to those in need. Those of us remaining at home must redouble our efforts to provide this care lest we furnish an excuse for governmental seizure of the medical resources of the country.

Briefly, I have tried to outline some of the major problems which we face during the coming year. Let's courageously face them together.

Presentation of Past-President's Button to Dr. Herbert E. White by Dr. David R. Murphey, Jr., the new President

DR. MURPHEY: Herbert, your term as head of the medical profession of the State of Florida has ended. I have enjoyed and will always remember my year of orientation under your capable leadership.

At the fortieth annual meeting held in Miami on April 14, 1913, this Association approved a motion by the late Dr. Ralph Greene authorizing the designing of a past president's button, this button to be presented each year at the close of the annual meeting to the outgoing president. A committee composed of Drs. Turck, McGinnis and Fernandez designed such a button which it is my privilege now to present to you. I am certain it is obvious to the membership of this Association the committee's objectives in designing this button.

Unlike old soldiers, past presidents do not fade away, and we are looking forward to your continued service on the Board of Governors of our Association.

I am certain that in years to come the year 1950-51 will stand out clearly in your memory. This will be particularly true in your leisure hours which previously you spent alone at home.

To remind you during your working hours of the deep affection in which the Association holds you, on its behalf I now take pleasure in presenting to you the past president's Certificate of Honor. Hang this on a wall in your office as a daily reminder of the years of service which you have rendered us.

Dr. White: "Thank you, Dave, and thanks to every member of the Association."

Dr. Murphey: "Is there any new business to come before the House?"

Dr. Murphey: "Are there any announcements?"

Dr. McIver announced that a meeting of the Board of Governors would be held in room 546 immediately after adjournment of the House of Delegates; that luncheon would be served to the Board there, and that the new secretary is to attend this meeting.

There being no further business, on motion from the floor, duly seconded and carried, the House of Delegates adjourned, sine die, at 12:10 p.m.

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:45 a.m., Monday, April 23, in The Sun Room with Dr. Frederick K. Herpel of West Palm Beach presiding. The following papers were read and discussed:

"Massive Resection of the Small Intestine, with Follow-Up Study of a Case," Julien C. Pate and Julien C. Pate, Jr., Tampa.

"The Use of Tantalum Mesh in the Repair of Hernias of the Abdominal Wall," Edward Canipelli and Joseph Canipelli, Jacksonville.

"Melanoma and Carcinoid* of the Rectum," Curtice Rosser, Dallas, Texas.

"Treatment of Urinary Frequency in Women," Joseph C. Hayward, Louis M. Orr, II, and James B. Glanton, Orlando.

Second Scientific Assembly

The second Scientific Assembly convened at 3:30 p.m., Monday, April 23, in The Sun Room with Dr. Frederick K. Herpel of West Palm Beach presiding.

The first speaker, Dr. Grayson Carroll, was introduced by Dr. Robert B. McIver.

The following papers were read and discussed:

"Antibiotics in the Treatment of Urinary Tract Infections," Grayson Carroll and Robert V. Brennan, St. Louis.

"Cerebral Arteriography," Maurice M. Greenfield and Christian Keedy, Miami.

"Experiences in Surgery of the Common Bile Duct," Alpheus T. Kennedy, Pensacola.

"The Role of Cancer Cytology in Medical Practice," J. Ernest Ayre, Miami.

Third Scientific Assembly

The third Scientific Assembly convened at 2:05 p.m., Tuesday, April 24, in The Sun Room with Dr. Jere W. Annis of Lakeland presiding. The following papers were read and discussed:

"Disabling Conditions of the Cervical Spine," Fred H. Albee, Jr., Eugene L. Jewett and Earl J. Powers, Orlando.

"Problems of Medical Care in Poliomyelitis," Kenneth S. Landauer, New York.

"Endocrine Relationships in Diabetes Mellitus and Carbohydrate Metabolism," Sidney Davidson, Lake Worth.

"Strokes — Their Diagnosis and Treatment," Richard E. Strain and Irwin Perlmutter, Miami.

"Malignancy During Pregnancy," Henry L. Harrell, Ocala.

Fourth Scientific Assembly

The fourth Scientific Assembly convened at 9:05 a.m., Wednesday, April 25, in The Sun Room with Dr. James L. Borland presiding. The following papers were read and discussed:

"Cancer of the Prostate," Joseph Q. Perry and Arthur J. Butt, Pensacola.

"Advancing Field of Thoracic Surgery," DeWitt C. Daughtry and John G. Chesney, Miami.

"Summary of Progress in the General Field of Health for the Period 1940-1949," Wilson T. Sowder, Jacksonville.

REGISTRATION

The registration for the Seventy-Seventh Annual Meeting at Hollywood surpassed that of any previous convention of the Association. The total number registered was 1,461 persons. The registrants included 768 members of the Association, 134 visiting physicians, 9 other guests, 380 members and guests of the Woman's Auxiliary and 170 representatives of exhibiting firms. There were 21 other states and Cuba represented.

Registration List

Officers

Herbert E. White, President	<i>St. Augustine</i>
David R. Murphy, Jr., President-elect	<i>Tampa</i>
Richard A. Mills, 1st Vice Pres.	<i>Ft. Lauderdale</i>
James H. Pound, 3rd Vice Pres.	<i>Tallahassee</i>
Robert B. McIver, Sec'y-Treas.	<i>Jacksonville</i>
Shaler Richardson, Editor	<i>Jacksonville</i>
Stewart G. Thompson, Managing Director	<i>Jacksonville</i>

Members

APALACHICOLA: Terry Bird. ARCADIA: Frank J. Liddy, Gordon H. McSwain, John A. Simmons. BARTOW: William F. Peacock. BELLE GLADE: Ralph L. Pipes. BELLEVIEW: Edwin C. Hanson. BOYNTON: Nathaniel M. Weems. BRADENTON: John E. Granade, Willis W. Harris, Millard P. Quillian, William D. Sugg, Willett E. Wentzel. BRANFORD: Edward G. Haskell, Jr. BROOKSVILLE: S. Carnes Harvard. BUNNELL: John M. Canakaris. CENTURY: Joe I. Tuberville. CHATTAHOOCHEE: Oswald A. Holzer, William D. Rogers. CLEARWATER: M. Eldridge Black, Raymond H. Center, William G. Mason. COCOA: Thomas C. Kenaston.

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DELRAY BEACH: Martin E. Buerk, Graham W. King, Jr., James R. Nieder. DUNEDIN: John A. Mease, Jr., Walter H. Winchester. EUSTIS: Louis R. Bowen, C. McK. Tyre. FERNANDINA: Henry B. Dickens, Jr. FT. LAUDERDALE: Norris M. Beasley, Robert E. Blount, Julius F. Boettner, Oliver C. Brown, Mark Butler, Russell B. Carson, Eugene C. Chamberlain, Alfred E. Cronkite, Frank Denniston, Burns A. Dobbins, Jr., Frederick J. Driscoll, Robert L. Elliston, Roland F. Fisher, Donald H. Gahagen, E. Borland Gill, George Hamerick, Jr., Anne L. Hendricks, Thomas F. Huey, Jr., Paul W. Hughes, Garland M. Johnson, M. Austin Lovejoy, Lloyd U. Lumpkin, Thomas L. McKee, Henry J. Peavy, Sr., William K. Peck, Claus A. Peterson, Francis D. Pierce, Raymond M. Price, George M. Rhodes, Jr., Thomas L. Roberts, Jr., Leigh F. Robinson, Curtis H. Sory, Rupert H. Stovall, Alva R. Taylor, James M. Weaver, William D. Wells, S. Elliott Wilson, Scottie J. Wilson.

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APRIL 27-30, 1952

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of the

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(Terms expire Dec. 31, 1952)
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(Term expires Dec. 31, 1952?)

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Proceedings of the Seventy-Seventh Annual Convention

1951

Hollywood, April 23-26

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DAVID RHODIN MURPHEY, JR., M.D., PRESIDENT

Dr. David Rhodin Murphey, Jr., was born in Anniston, Ala., on July 27, 1906. He received the B.A. degree from the University of Alabama in 1926, the M.D. degree from the Vanderbilt University School of Medicine in 1930 and the degree of M.S. in Surgery from the University of Virginia School of Medicine in 1933. From 1930 to 1935 he was Resident in Surgery and duPont Fellow in Surgical Pathology at the University of Virginia Hospital. During 1932, he also served as Fellow in Surgical Pathology at the Johns Hopkins Hospital. He had further graduate training at the Kelly Hospital in Baltimore and the Memorial Hospital for the Treatment of Cancer and Allied Diseases in New York City.

Since 1935 Dr. Murphey has engaged in the private practice of surgery in Tampa. He is Medical Director of the Hillsborough County Civil Defense Commission, Director of Surgery at the Tampa Municipal Hospital, and a member of the active staff of St. Joseph's Hospital.

During World War II, Dr. Murphey served in the Air Corps from June 1942 until February 1946, when he was discharged with the rank of lieutenant colonel.

A past president of the Hillsborough County Medical Association, Dr. Murphey has served on the Board of Governors of the Florida Medical Association since 1946. He is also a past president of the Florida Blood Bank Association and was particularly active in establishing the Southwest Florida Blood Bank, prior to World War II.

Dr. Murphey is a member of the American College of Surgeons, the American Medical Association, the Southeastern Surgical Congress, the Southern Surgeons Club, and the Southern Surgical Association.

At Vanderbilt, Dr. Murphey was elected to Alpha Omega Alpha and served as president. His social fraternity is Phi Gamma Delta and his medical fraternity is Alpha Kappa Kappa. He was elected to Sigma Xi, national research fraternity at the University of Virginia.

In 1931, Dr. Murphey was united in marriage to Miss Caroline Gaines of Jasper, Ala. They have two children, David R. Murphey, III, and Benton Rogers Murphey.

The Journal of the Florida Medical Association

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Seventy-Seventh Annual Convention Largest in History

All previous attendance records were broken as Association members from throughout the state assembled at Hollywood for the Seventy-Seventh Annual Convention, April 22-25. Registration figures show a total attendance of 1461. Of these 768 were members, 134 were visiting physicians, 9 were other guests, 380 were members and guests of Woman's Auxiliary, and 170 were representatives of exhibiting firms. The list of members, visiting doctors, and guests registered at the convention is contained in this Journal at the end of the proceedings on page 803.

Over a thousand members and guests enjoyed the carnival atmosphere at the annual Smoker on Monday evening. At the Association Dinner on Tuesday evening 626 plates were served. Near capacity attendance at these functions make necessary exercising great care in the selection of convention sites in order that adequate facilities are available.

Four scientific assemblies, three general sessions and two meetings of the House of Delegates were crowded into two and one-half days, from Monday morning until Wednesday noon. At the second general session retiring president, Dr. Herbert E. White, presented an expansive address. An action of the House of Delegates on Wednes-

day morning transferred this annual address of the president to a meeting of the House for future years.

On Sunday the facilities of the Hollywood Beach Hotel were taxed to provide assembly rooms for simultaneous meetings of eighteen specialty groups. A number of out-of-state speakers who addressed specialty groups also appeared on the Association's scientific program.

The three reference committees appointed by the president gave careful consideration to committee reports and resolutions presented at the first meeting of the House of Delegates. Their study and recommendations on these measures aided greatly in the dispatching of business at the second meeting of the House.

In no small measure was the outstanding success of the 1951 convention due to the time and efforts of the FMA convention committees under the guidance of Dr. Milton N. Camp, general chairman. A total of 43 members served on 10 committees.

The officers and members of the Association are deeply appreciative of the many fine exhibits that filled the 145 feet by 90 feet Great Lounge to overflowing. The popularity of attractively displayed scientific exhibits proved their value

to the doctors. Technical exhibitors presented a wealth of information in the way of latest developments in pharmaceuticals and equipment.

An innovation in the exhibit hall was a booth for exclusive use by county medical societies. Interesting and informative displays were put on by the Dade County Bulletin, whose April issue was dedicated to the Florida Medical Association, and the Picomeso Mail Bag of the Pinellas County Medical Society. It is hoped that at future meetings more county societies will utilize the facilities of this booth. Adequate space will be provided.

The annual convention for 1952 is scheduled again for Hollywood with the Hollywood Beach Hotel as headquarters. The dates for this meeting have been set by the Board of Governors for April 27-30.

On the preceding pages of this Journal may be found the complete text of recommendations of the reference committees and actions taken by the House of Delegates.

Convention Golf Tournament

Top FMA golfer for 1951 is Dr. John D. McKey of Orlando, who paced the annual convention tournament with a low net score of 70. As first place winner, Dr. McKey was presented the Orlando Loving Cup by last year's victor, Dr. William G. Meriwether of Plant City. The contest was waged over the colorful Hollywood Beach Country Club course on April 22, 23 and 24.

Other winners were, in order, Dr. Joseph L. Hundley of Orlando who received the second place prize of a golf bag; Dr. J. Brown Farrior of Tampa who claimed the third place prize, a caddy cart; and Dr. Colquitt Pearson of Miami who placed fourth and was awarded an umbrella and bag for practice balls.

Dr. McKey will retain the Orlando Cup until next year's tournament at which time golfing doctors will again compete for this award. Donated by the Orange County Medical Society at the annual meeting of the Florida Medical Association in Orlando in 1931, the Cup has now been competed for eighteen times with sixteen different winners. During the war years of 1942, 1943 and 1944, no tournaments were held. Any member will be granted permanent possession of the Cup after having won it three times. So far only two members have won more than once. Dr. Mozart A. Lischkoff of

Pensacola won the Cup in 1931 and 1935. Dr. Clarence A. Rudisill of Tampa claimed it in 1932 and again in 1942.

Prizes were presented at the annual Association Dinner at the Hollywood Beach Hotel, Tuesday night, April 24. The awards were made by Dr. Lloyd U. Lumpkin, Ft. Lauderdale, chairman of the FMA golf committee.

Professional and Geographic Background of Distinguished Offspring

Who rules industry? Some years ago Mr. Roger Babson made a study of the heads of 100 leading industries. He found that by far the greatest number of these outstanding industrialists were the sons of professional men. Five per cent were the sons of bankers, 10 per cent were the sons of merchants and manufacturers, 25 per cent were the sons of physicians and country lawyers, and over 30 per cent were the sons of ministers.

A recent study indicates that families of professional men produce twice as many distinguished offspring as the families of business men, 20 times as many as farmers, 45 times as many as skilled laborers and 1,000 times as many as unskilled laborers.

In his research on leading Americans born and reared in Indiana, Dr. Stephen S. Visser directed attention not only to the value of a parent from professional life but also to the role of geographic background in the success struggle. Indirectly, he concluded, one's economic status and place in the community may be greatly influenced by the geographic location of his birthplace.

"The areas which yield the most notables," this professor of geography at the University of Indiana recently told the Association of American Geographers, "are those which contain the most mentally alert, ambitious, persistent and energetic people possessed of high ideals. Such people seek opportunities to use their abilities, they appreciate congenial associates and therefore congregate in desirable towns and in choice residential districts or in suburbs."¹ It appears that one who wishes to succeed in life would do well to be discriminating both as to birthplace and parents.

1. For Success, Choose Birthplace Carefully, Science News Letter, March 31, 1951, p. 201.

June Anniversaries

JUNE 1. Andreas Vesalius, one of the greatest men in all medical history, was born near Brussels in 1514. He studied medicine at Louvain, Montpellier and Paris. During the years 1537 to 1546, while teaching anatomy at Padua, he demonstrated his magnificent gifts of observation and description. One historian has said, "Vesalius tried to believe Galen rather than his own eyes, but his eyes were too strong for him; and in the end he cast Galen and his writings to the winds, and taught only what he himself had seen and what he could make his students see, too."

On June 1, 1543, Vesalius' epoch-making work titled "De humani corporis fabrica libri septem" was published. Illustrated with excellent engravings by Stephen Calcar, the work became, in the opinion of some authorities, the greatest medical book ever written—the book which marks the beginning of modern medicine.

In contradicting the authority of Galen, Vesalius brought storms of criticism from many sources upon his head. Plagued by hostile attacks from men like Sylvius, a former teacher, and Columbus, a well known anatomist, Vesalius left Padua in 1546 to become physician to the court of the Emperor of Spain at Madrid. Although he had no opportunity to pursue his studies there, he was gratified to follow the progress of the "new anatomy" in the works of Fallopius, his successor at Padua.

In 1563, perhaps as penance for accidental human vivisection, Vesalius made a pilgrimage to the Holy Land. Apparently he hoped to resume his duties at Padua following this trip, but on the return journey from Jerusalem his ship was wrecked at Zanti, where he died, not yet 50 years old, of an illness which probably was typhoid fever.

Vesalius deserves to be known as the founder of the real science of anatomy and, with Harvey, he should share the honor of having placed medical science upon a basis of fact rather than tradition.

JUNE 2. Louis Pasteur's first great success in protecting sheep against anthrax was demonstrated on June 2, 1881.

JUNE 14. Aristotle of Stagira, Greece, was born in 384 B.C. Supplied with funds and materials for investigation by his famous pupil, Alexander the Great, Aristotle observed the effects of food, drugs and climate on both man and animal. As comparative anatomist and zoologist, Aristotle

deserves to be known as the founder of the study of natural history. He died on June 14, 322 B.C., perhaps a day or so before the death of his famous pupil.

JUNE 18. Charles Louis Alphonse Laveran of Paris was born on June 18, 1845. A worker in parasitology for forty-two years, most of which were spent at the Pasteur Institute, Laveran first observed the malarial parasite in human blood in 1880, while serving as an army surgeon in Algeria. Laboring six days a week from 8 a.m. to 8 p.m., with no relaxation except for a short lunch, Laveran clearly showed that he preferred the laboratory to promotion in rank. He received the Nobel Prize in 1907.

JUNE 21. In September 1765 there appeared in the Pennsylvania Gazette an announcement of the School of the College of Philadelphia, first medical school in the United States (now the University of Pennsylvania), with courses offered by Dr. William Shippen, Jr., and Dr. John Morgan. The first degrees (M.B.) were conferred upon eight graduates on June 21, 1768.



Frontispiece of the first edition of "De humani corporis fabrica libri septem," 1543.

Passano Award for Blood Research

On June 13, 1951, the day after he accedes to the presidency of the American Medical Association, Dr. John W. Cline of San Francisco will be the guest speaker at the Passano Foundation Award dinner at the Marlborough-Blenheim Hotel in Atlantic City. The \$5,000 cash award goes this year to two distinguished investigators for their work in blood research. It will be conferred jointly upon Dr. Alexander S. Wiener of Brooklyn, N. Y., who is connected with the Department of Forensic Medicine of New York University-Bellevue Medical Center, and Dr. Philip Levine, who directs the Rh Testing Laboratory of the Ortho Research Foundation at Raritan, N. J.

The Passano Foundation was established in 1943 by the Williams & Wilkins Company, medical publishers of Baltimore, to aid in the advancement of medical research, especially that which bears promise of clinical application.

Night and Emergency Call Systems

Adequate coverage of night and emergency calls is a necessary part of the program of improved public relations. It is likewise, in the light of present civilian defense preparations, an essential part of any emergency medical care program.

Local medical societies have made excellent progress during the last three years in establishing night and emergency call plans. A national survey in the summer of 1948 disclosed that 60 plans of this nature were in operation. This January, two and one-half years later, another survey revealed that 329 such plans were established and functioning.

These plans vary widely according to the size of the community served, but they all have the same objective — to guarantee that the people of the community can obtain a physician at any time of the day or night every day in the year. Traditionally, physicians have taken care of their own patients to the best of their ability, answering calls at all hours. When away, they make provision for another doctor to take over their practices, and they train their office staffs and families to handle calls when they are not available for other reasons. But there are always those who have no family physician, persons who become ill away from home, and patients who cannot locate their physician in an emergency. For these groups the medical profession also has a responsibility, which can be met collectively through night and emergency call plans.

In Florida, practically all of the larger county societies have formed Medical Service Bureaus in an effort to assist the public in getting in touch with doctors day and night during emergencies. While much progress has been made in this respect in this state and in the nation, there remain communities where no plan for this service is functioning although one could be established. So long as this provision is lacking, newspapers will continue to publish harrowing tales of tragedies that might have been prevented if a physician could have been located.

Obviously, all the improved technics and increased knowledge of modern medicine are of no avail to the patient unable to locate a physician when illness strikes. It is, therefore, strongly urged by the Board of Trustees of the American Medical Association that all county medical societies without a formal plan for answering night and emergency calls make such a project a primary objective during this year. It seems hardly necessary to urge every member of the Association to cooperate in this important aspect of service.

Treatment of Veterans

Authorization of Treatment for Veterans

Outpatient services may only be rendered to veterans for their service connected disability and only when authorization in advance of the services by the Veterans Administration Regional office. Authorizations are issued in eligible cases, for services during that month. Emergency treatment of service connected disabilities together with the circumstances requiring this treatment should be reported to the Veterans Administration Regional office within ten days. It should be stated in reporting the treatment whether it was or was not practical to send the veteran to a government hospital for treatment.

Writing Prescriptions for Veterans

It is the responsibility of the physician to certify on prescriptions that he is authorized to prescribe for the patient. The physician should be sure to limit such services for veterans to the month for which he has received authorization. The physician should write above his signature on the prescription: "I am authorized to prescribe for and treat the above named veteran."

Announcement

It has been learned that a few physicians have charged veterans a fee in addition to the established fee which they receive from the Veterans Administration for treatment of the veteran. This is a violation of the terms of the contract between the Florida Medical Association and the Veterans Administration. Physicians who charge veterans an extra fee in addition to the fee which they receive from the Veterans Administration will be removed from the list of participating physicians.

Sub-Committee of the Board of Governors
on Veterans Care

Frederick H. Bowen, M.D., Chairman

YOUR BLUE SHIELD

Blue Shield Annual Meeting Election of Board Members

The annual meeting of the Active Members of the Florida Blue Shield Plan was held on April 22 in Hollywood Beach, Florida, preceding the annual meeting of the Florida Medical Association. Four doctors and one layman were elected by the active members to fill vacancies on the Board of Directors, which vacancies were brought about by the expiration of five terms of office. Those elected to serve for terms of three years each on the Board of Directors are: Walter C. Payne, M.D., Pensacola; Leonard Wesson, Tallahassee; Frederick J. Waas, M.D., Jacksonville; David R. Murphy, Jr., M.D., Tampa; Leigh F. Robinson, M.D., Fort Lauderdale.

Election of Officers

At the annual meeting of the Board of Directors held immediately following the meeting of active members, the following officers were re-elected for the ensuing year: Leigh F. Robinson, M.D., Fort Lauderdale, president; Walter C. Jones, M.D., Miami, first vice-president; Mother Loretta Mary, St. Joseph's Hospital, Tampa, second vice-president; Herbert E. White, M.D., St. Augustine, secretary, and Frederick J. Waas, M.D., Jacksonville, treasurer.

* * *

Blue Cross - Blue Shield Home Office

The Florida Blue Cross and Blue Shield Plans are now located in their new home office at 532 Riverside Avenue, Jacksonville. The move to the new quarters was made over the week-end of

April 14 and was so efficiently carried out that Plan operations were resumed on the morning of April 16.

Formal opening of the new building was held on Saturday, May 19, from three until six p.m. At that time physicians, hospital people, members and friends visited and inspected the new offices.

In the short time that the two plans have been located in the new home office there has been a noticeable increase in efficiency and economy of operation. In addition to the decrease in operating expenses brought about by increased efficiency, the amount of rent saved over a period of ten years will more than offset the cost of constructing the building. Prior to their move, the Blue Cross and Blue Shield Plans were located in three office buildings in downtown Jacksonville, the total annual rental for which was \$26,000.

The Blue Cross and Blue Shield Plans extend a cordial invitation to all participating physicians and their staffs to visit the new home office. A personal inspection of the new offices will reveal how the Plans are now able to be of greater service to members, physicians and hospitals.

MARRIAGES AND DEATHS

Marriages

Dr. Harold Sutker and Miss Suzanne Ellen Turkel, both of Tampa, were married on April 15, 1951.

Dr. Alan E. Bell and Miss Addie Virginia Hamilton, both of Pensacola, were married on April 7, 1951 in Gainesville.

Deaths — Members

Bowen, John T., Clearwater	March 16, 1951
Macdonald, John T., Miami	April 3, 1951
Glenn, Robert B., Jacksonville	April 25, 1951
Wallace, James E., Jacksonville	April 25, 1951
Hardgrave, George L., Clarksville, Ark.	
(Reported killed in action)	May, 1951

Deaths — Other Doctors

Carlson, Carl W., Woodhull, Illinois	Jan. 6, 1951
Miller, John, Greenwich, Conn.	Jan. 14, 1951
Lingeman, Ralph B., Rochester, New York	April 6, 1951
Sibert, Aldo Vernon, West Palm Beach	April 24, 1951

Errata — J. Florida M. A. October 1950

Coleman, Senator R., (Col.) DeLand	June 25, 1945
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STATE NEWS ITEMS

Dr. Samuel M. Day of Jacksonville, newly elected secretary-treasurer of the state Association, was guest speaker at the May meeting of the Junior League of Jacksonville which was held at the Florida Yacht Club.

Dr. Herbert M. Webb, Jr., of Wildwood recently led a question and answer period on cancer at a meeting of the Wildwood Woman's Club, following the presentation of the film, "Breast Self-Examination."

Dr. Samuel G. Hibbs of Tampa was the principal speaker at a recent meeting sponsored by the Tampa Regional Mental Hygiene Society and held in the Lakeland High School Auditorium.

Dr. Russell W. Ramsey of Winter Park recently gave a talk on cancer detection and cure to the women of Winter Park at the Colony Theatre. Following his talk, the showing of the film, "Breast Self-Examination," was made possible through the cooperation of the Orange County Cancer Information Center, the Winter Park Woman's Club and the Colony Theatre.

Dr. Oscar L. Kelley of Palm Beach was guest speaker at the meeting of the local Northboro Junior High Study Group recently. He spoke on heart trouble.

Dr. Lowell S. Selling of Orlando recently addressed the psychiatric section of the Academy of Forensic Sciences in Chicago.

Dr. Frank G. Slaughter of Jacksonville was recently re-elected to serve as president of the Tuberculosis Association of Duval County for the fourth term.

Dr. Clarence W. Ketchum of Tallahassee recently addressed the executive committee members of the Woman's Auxiliary of the Tallahassee Memorial Hospital on the functions and practices of the hospital laboratory.

Dr. Herbert M. Webb, Jr., of Wildwood has accepted a residency in obstetrics at the Jackson Memorial Hospital in Miami.

Dr. J. Basil Hall of Mount Dora was guest speaker at a recent meeting of the Eustis Health and Welfare Council which was held in the Grand View Hotel.

Dr. Walter B. Tomlinson of Warrington recently addressed the local Annie McMillan Parent-Teacher Association on the subject of heart disease.

Drs. J. Rocher Chappell and Roger W. Gridley of Orlando participated in the program at the recent meeting of the private duty section of District No. 8, Florida State Nurses Association which was held in the Orange Memorial Hospital.

Dr. Samuel S. Lombardo of Jacksonville recently addressed an open meeting of Today's Women at the Southside Branch Library. His subject was cancer.

Dr. Thomas H. Bates of Lake City was recently elected president of the Atlantic Coast Line Surgeons Association.

Dr. Albert V. Hardy of Jacksonville has departed this country for Korea where he will set up and direct a study of dysentery. Dr. Hardy has been granted emergency leave by the Florida State Board of Health at the request of the Armed Forces Epidemiological Board.

Dr. Joseph S. Stewart of Miami was installed as president of the Southeastern Surgical Congress at its meeting in Hollywood, April 11-14. Dr. Stewart also served as co-chairman of the meeting along with Dr. Walter C. Jones of Miami.

At the scientific sessions papers were presented by Drs. Perry D. Melvin, Milton M. Coplan and Frank M. Woods, all of Miami, and Ashbel C. Williams of Jacksonville.

Dr. Robert B. McIver of Jacksonville was a guest speaker at the April meeting of the Dade County Medical Association.

Dr. John W. Williams of Lakeland has led question and answer discussions on parathion poisoning at recent meetings of the following county medical societies: Brevard, DeSoto-Hardee-Highlands-Glades, Indian River, Lake, Manatee, Orange, Pasco-Hernando-Citrus, Polk, St. Lucie-Okeechobee-Martin, Sarasota, Seminole and Volusia. Pinellas County answered its question on parathion poisoning through its Picomeso Mail Bag.

The preventative measures in connection with this spray were discussed by representatives of the University of Florida Citrus Experiment Station at Lake Alfred.

Mr. Tom Jarvis of Jacksonville has been selected by the Board of Governors as assistant supervisor of the Bureau of Public Relations.

Mr. Jarvis comes to the Association from a background of experience in newspapers and periodicals. His immediate employment before joining the Association was with the Florida Times-Union, Jacksonville daily newspaper.

Dr. Howard P. Knapper of St. Petersburg recently addressed the local Shrine Club's luncheon. His subject was on plastic surgery.

The following doctors have been granted honorary membership by the Board of Governors: Drs. Lydia Allen DeVilbiss, Hewitt Johnston, Charles L. Kennon, Geo. N. MacDonell, Elbert McLaury, Alice R. Miller, Ernest Henry Ruediger, L. H. Paul, N. J. Dawkins, and Heyward J. Blackmon.

A list of residencies in approved hospitals in which positions are open is available from the Residency Information Service, Council on Medical Education and Hospitals, American Medical Association, 535 North Dearborn St., Chicago 10, Ill. This is a new service initiated by the Council early in May.

FOUND: One standard make fountain pen and one pair of horn-rimmed sunglasses. Turned in at registration desk at Hollywood convention. Owners may reclaim articles upon reasonable identification.

Dr. Robert B. McIver of Jacksonville was one of the featured speakers on the program of the annual meeting of the American Urological Society held in Chicago, May 21-24.

Dr. J. Dillard Workman of Live Oak recently addressed the local Rotary Club on the problems and cost of a medical career.

Dr. Sullivan G. Bedell of Jacksonville was a recent speaker at a meeting of the staff members of the University of Florida's Office of Student Personnel in Gainesville.

Dr. Joseph D. Scolaro of Tampa has been named chairman of the 1952 Community Chest campaign in Ybor City.

Dr. Mozart A. Lischkoff of Pensacola was elected president of the Alumni Association of the Ear, Eye, Nose and Throat hospital at its annual convention in New Orleans in May.

Dr. Amsie H. Lisenby of Panama City recently addressed the local Junior Chamber of Commerce on socialized medicine.

Dr. William C. Thomas, Sr., of Gainesville was a guest speaker at a recent meeting of the local Rotary Club. He compared the death rates for infants in Alachua County and the nation.

Dr. Robert C. Lonergan of St. Petersburg attended the Fifth Congress of the International Society of Orthopedic Surgery and Traumatology which was held in Stockholm, Sweden, May 19-26.

Dr. Jere W. Annis of Lakeland recently addressed the local Kiwanis Club on the progress made in dealing with heart ailments.

WANTED — FOR SALE

Advertising rates for this column are \$5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

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COMPONENT SOCIETY NOTES

Bay

The April meeting of the Bay County Medical Society was held jointly with the Tyndall Air Force Hospital Staff at the Tyndall Hospital mess hall. A paper on the newer medical aspects of atomic energy was presented by Major B. W. Prior.

Dade

The Dade County Medical Association held its regular monthly meeting on Tuesday, May 1. Dr. Russell Haden, Medical Director, National Blood Program, was the guest speaker and chose for his subject, "Blood and Blood Substitutes."

Hillsborough

The regular monthly meeting of the Hillsborough County Medical Association was held in the Floridan Hotel in Tampa on May 1. Dr. Herschel G. Cole presented a paper on "New Developments in Hip Surgery," and Dr. J. Brown Farrior presented a paper on "Nasal Surgery, Old and New."

Marion

At the regular monthly meeting of the Marion County Medical Society, which was held at the Marion Hotel in Ocala, Dr. S. Carnes Harvard of Brooksville spoke on the general consideration of accident injuries.

Members attending included Drs. William H. Anderson, Jr., John J. Cheloden, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, John D. Lindner, John N. Moore, Robbins Nettles and Eugene G. Peek, Jr., Ocala, and Dr. William H. Garvin, Jr., Dunnellon.

Palm Beach

At the regular monthly meeting of the Palm Beach County Medical Society, Dr. Arthur C. DeGraff, professor of therapeutics at New York University Medical College, gave a talk on the newer concepts of the pharmacologic action of the digitalis glucosides.

Pinellas

The Pinellas County Medical Society held its regular monthly meeting at the Detroit Hotel in St. Petersburg on May 7. The scientific program was in charge of Dr. Horace D. Atkinson of St. Petersburg.

Taylor

All members of the Taylor County Medical Society have paid their state dues for 1951.

WOMAN'S AUXILIARY

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President's Message

The Woman's Auxiliary to the Florida Medical Association has come of age. The realization of this was shared by all who attended the state convention in Hollywood.

Although constant efforts were made throughout the year to achieve this stature, the enthusiasm, large attendance and stimulating discussion exhibited at the meeting gave one the feeling that "it grew up while we weren't looking." And with justifiable pride we are taking new measures to cover adequately the expansion.

Like out-grown clothes, the time assigned to cover the business wasn't sufficient. Business sessions which had been streamlined to handle Auxiliary affairs in the shortest length of time to release members to amusement, had to be prolonged because of the interest shown in the issues which were brought up.

This increased membership of thinking women from all parts of Florida had come to learn. They stayed, listened and offered constructive ideas. A general attitude prevailed that one day out of the year was not too much to give to Auxiliary affairs which affected the welfare of the doctors throughout Florida.

The talk given by Dr. David R. Murphey, Jr., of Tampa, incoming president of the Florida Medical Association, further emphasized the fact that we are not a separate unit but a "team" with the Medical Association and it was the team-work in the past which proved our worth.

Dr. Homer L. Pearson, Jr., of Miami, gave an inspiring and stimulating talk at the Auxiliary



*Mrs. C. Robert DeArmas,
President, Woman's Auxiliary*

luncheon which further clarified the status of the Auxiliary in relation to the doctor. No one could have listened to these two doctors and still wonder how we achieved maturity.

At the first meeting of the General Assembly, Dr. Herbert E. White, retiring president of the Association, graciously introduced your then president-elect, who in turn, had the pleasure of presenting Mrs. Arthur Herold, the National Auxiliary president, who is from Shreveport, La.

It is our ardent hope that the nineteen Auxiliaries that were represented by their presidents will join in our enthusiastic plan to become educated on the local level. We urge them to keep in touch, study and discuss issues which come up for their consideration at home, so that they may adequately instruct their delegates in the expression of their group and in so doing make our annual meeting a vigorous action session.

We have much to do . . . and we need each of you. If you dignify your work with a sense of responsibility you will interest other responsible people and by so doing will aid us in our aim to reach the unorganized counties in Florida.

Mrs. C. Robert DeArmas
President

BOOKS RECEIVED

SANTA CLAUS, M.D. By W. W. Bauer, M.D. Price \$2.75. Pp. 266. New York, The Bobbs-Merrill Company, Inc., 1950.

This very readable book presents the physician's side of the hot controversy between advocates of compulsory health insurance and the medical profession. It sets forth for layman, patient, taxpayer and voter alike the conviction of the physician and his colleagues that politics and medicine will not mix, that any compulsory insurance is an inferior prescription which cannot improve one's health as effectively or as economically as an improvement and extension of existing plans.

Here is exploded the myth that the people of this country are in poor health. Here it is shown that Uncle Sam, in the role of combined Santa Claus-family doctor, can never fulfill the glittering promises to cure all of one's aches and pains with "free" medical care. One is cautioned to remember that when Uncle Sam starts posing as Santa Claus, M.D., he has no money but the people's money with which to pay the bills.

Dr. Bauer, well known author, editor of *Today's Health* (formerly *Hygeia*) and since 1932 Director of Health Education of the American Medical Association, explains the constructive health program of the more than 140,000 American physicians today. He makes it clear that the superior health of the American people is no accident. It is based on the growing effectiveness of medical care, hospitalization, nursing and research, which have been nurtured by physicians quietly and persistently for many years, indeed since long before the modern agitation for compulsory health insurance was begun.



THE COOK BOOK FOR LOW SODIUM DIET. By Reena Roberts Hasker, B.S., M.A. Price, 20 cents. Pp. 55. Boston, The Massachusetts Heart Association, Inc., 1950.

This practical booklet is written for one who does the cooking for a person on a sodium-restricted diet by order of his physician. Of equal importance, the needs of the other members of the family who are not on a restricted diet are given due consideration. This guide to a balanced, wholesome diet, with small modifications plainly noted, lightens the day to day task of keeping the entire family well fed and happy.

The recipes of tested goodness and the menus, interesting, varied and nourishing, offer ample assurance that a low sodium diet need not be a poor compromise with good eating. Instead, here is convincing evidence that it is excellent fare.

This cook book may be obtained in quantity by physicians from the Florida Heart Association, Inc., P. O. Box 587, St. Petersburg 1, Fla., or it may be obtained by the patient on presentation of the physician's prescription slip. Copies will also be supplied to dietitians and other professionally interested persons upon request. The very low price of 20 cents merely covers the cost of printing and mailing.

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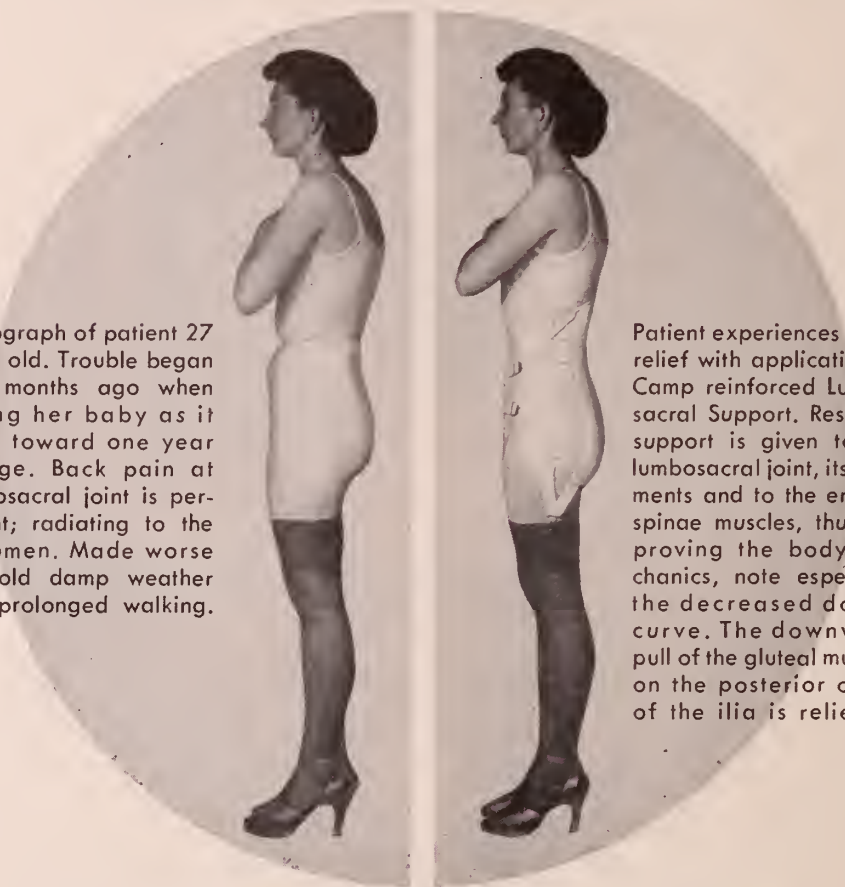
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From where I sit
by Joe Marsh

The Cow That Can't "Run Dry"

Sandy Johnson showed me his Jersey cows last week. It was a warm day and they were all under the trees near a watering trough.

And darned if one cow wasn't pumping water into the trough! It's a fact—she'd raise the pump handle with her nose, and use her throat to push it down again.

"That's Mabel," Sandy explained. "Sometimes they drink that trough dry, and she's learned how to fill it again. But she doesn't know her own strength—turns the place into a swamp if we don't watch her."

From where I sit, Mabel isn't the only one who doesn't know where to stop. For instance, people who carry their ideas too far—like those who would tell a man how to practice his profession . . . like those who would tell their neighbors what beverage to choose. I prefer a glass of beer with my meals. I know that a lot of other people prefer milk. But nobody ought to insist on "herding" others to his way of thinking.

Joe Marsh

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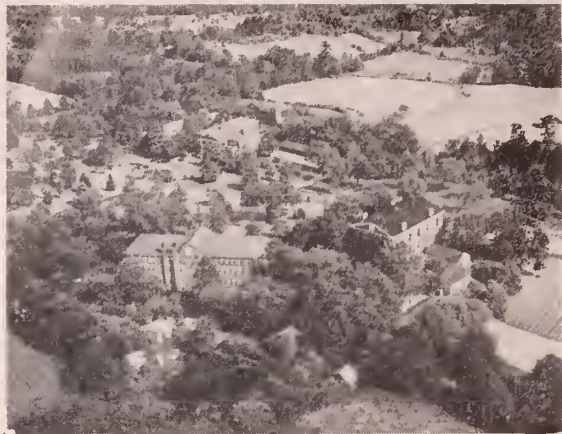
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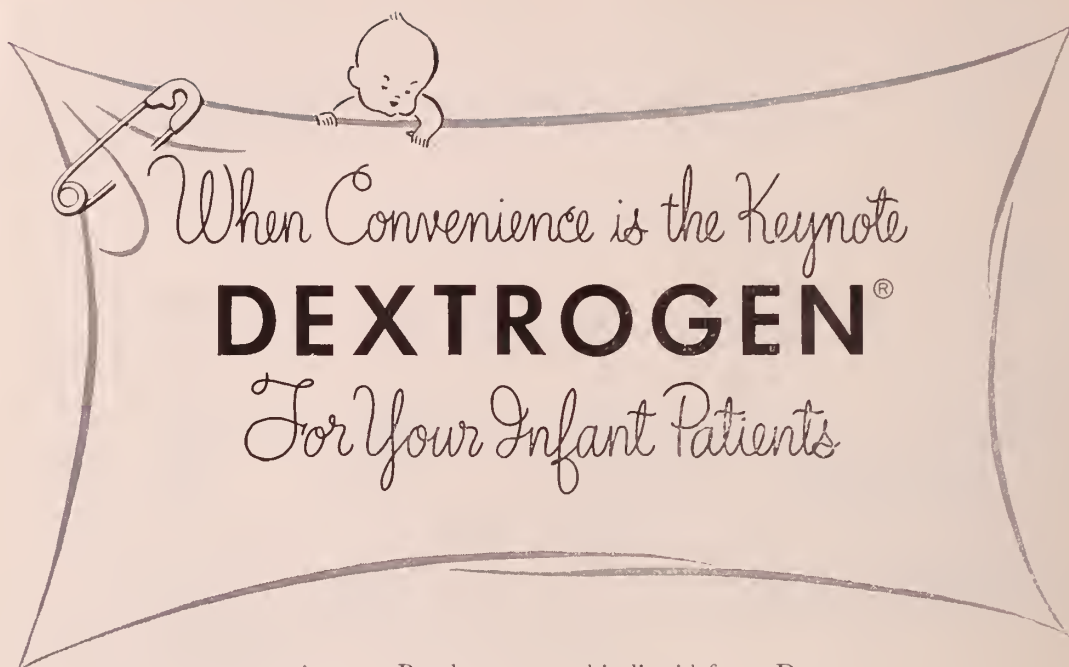
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The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

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NOTE HOW SIMPLE TO PREPARE

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*

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Each teaspoonful (5 cc) of Elixir Choline Chloride (Taberoc) supplies one gram choline chloride. It supplies more choline base than most preparations available for clinical use.

Elixir Choline Chloride (Taberoc) should be taken after meals and preferably mixed with half glass cold water.

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Only 47.1 per cent of patients can be fitted with a size 70 or 75 diaphragm¹ (the most commonly prescribed sizes).

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Thus, the need for correct fitting and a wide range of diaphragm sizes is evident. A diaphragm which is too small or too large will not block access to the cervix along the anterior wall.²

Ramses® Patented Flexible Cushioned Diaphragms are available in sizes ranging from 50 to 95 millimeters inclusive, in gradations of 5 millimeters.

Only the "RAMSES" Diaphragm is made with the comfort-assuring patented cushioned rim. Only the "RAMSES" Diaphragm is made with a velvet-smooth pure gum rubber dome.

The "RAMSES" Diaphragm is intended for use with "RAMSES" Vaginal Jelly to provide optimum protection for the patient.

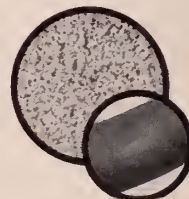
1. Clark, Le M.: The Vaginal Diaphragm. St. Louis, C. V. Mosby Company, 1938; p. 43.
2. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams & Wilkins Company, 1950; p. 17.



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Unretouched photomicrograph of the dome (enlarged 10 diameters) and the rim (inset) of a "RAMSES" Flexible Cushioned Diaphragm.



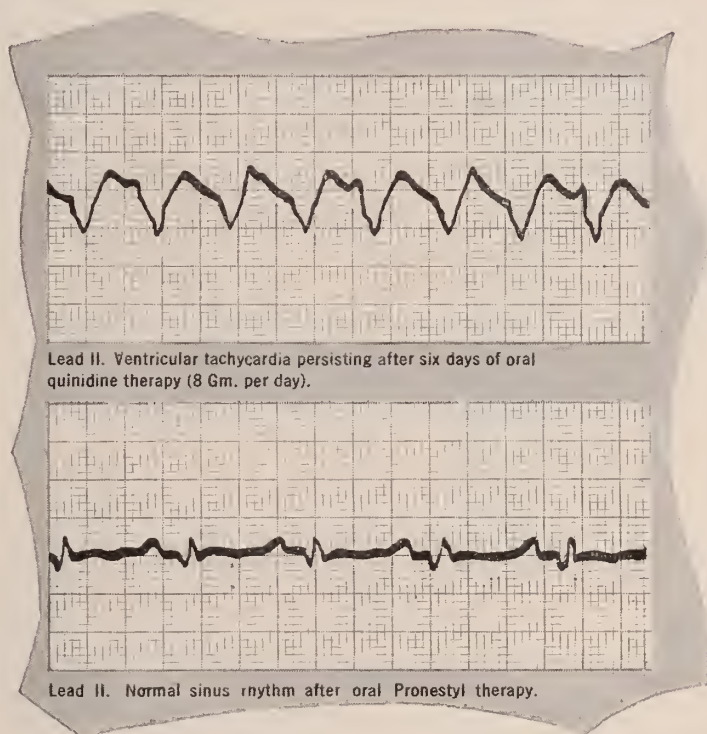
Unretouched photomicrograph of the dome (enlarged 10 diameters) and the rim (inset) of a conventional-type diaphragm.

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Squibb Procaine Amide Hydrochloride



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Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
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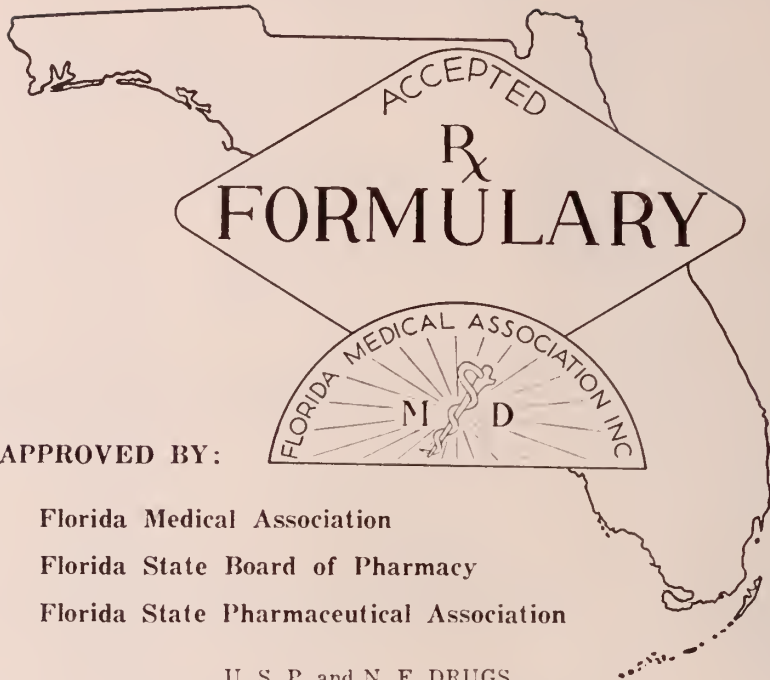


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As at the other end of the age gamut, optimal nutrition can make a tremendous difference in the vigor and stamina of the oldster.^{1,6,8-11} Many geriatricians stress the importance of vitamin C in the management of geriatric diets,^{2,5,9} and recommend a fully adequate intake^{5,9} of citrus fruits and juices (so often neglected by older people)—because of their high content of this essential vitamin and of other nutrients. Fortunately most everyone likes the taste of Florida citrus fruits and juices. They may be served in a variety of ways, and—under modern techniques of processing and storage, whether fresh, canned or frozen—they can *retain their ascorbic acid content*,^{3,7} and *their pleasing flavor*,⁴ in very high degree and over long periods.

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Citrus fruits—among the richest known sources of Vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid!

References:

1. Chlodek, M.: M. Rec., 138:736, 1945.
2. Gordon, F. S.: Nutrition and Vitamin Therapy in General Practice, Year Book Publishers, Chicago, 1947.
3. Krehl, W. A. and Cowgill, G. R.: Food Research, 15:179, 1950.
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8. Sadow, S. F.: M. Woman's J., 50:68, 1941.
9. Stephenson, W., et al.: Brit. M. J., 2:830, 1941.
10. Stieritz, E. J.: J. A. M. A., 142:1070, 1950.
11. Thewlis, M. W.: The Care of the Aged, 5th ed., Mosby, 1946.



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In one out of six patients



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but *all* 34 patients in this study carried *Endamoeba histolytica*¹ in their stools! Five were classified as asymptomatic and 18 were "persons with such poorly defined symptoms that they would not normally seek medical assistance..." but a stool examination proved that all had amebic dysentery.

In these instances, a course of treatment with Milibis-Aralen was completely successful. Milibis — bismuth glycolylarsanilate — a new intestinal amebicide, is one of the most powerful of the drugs commonly used

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Aralen (chloroquine) diphosphate has been shown to exert a specific action on extra-intestinal amebiasis. The combination of Aralen with a superior intestinal antiamebic drug such as Milibis furnishes adequate treatment of any amebic infection.

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Aralen, tablets of 0.25 Gm., bottles of 100.

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
Florida Medical Districts	William C. Roberts, Panama City	Council Chairman	
A-Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Pensacola, 1951
B-Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Orlando, 1951
C-Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	Bradenton-Sarasota, 1951
D-Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Vero Beach, 1951
Florida Specialty Societies			
Academy of General Practice	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	Hollywood, Apr. 27, '52
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	
Anesthesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Coll. Chest Phys.	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
Derm. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
Health Officers' Society	Ferry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
Ophthalm. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
Pathological Society	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Lauderdale	" "
Pediatric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	" "
Radiological Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
Urological Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 2, '51
Blood Banks, Association	William C. Thomas, Sr., Gainesville	James M. McClamroch, Gainesville	
Dental Society, State	D. Morrison, Sr., D.D.S., Gainesville	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, Dec. 3-4, '51
Hospital Service Corporation	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 2, '51
Medical Examining Board	William C. Thomas, Sr., Gainesville	Homer L. Pearson, Jr., Miami	Jacksonville, June 24-26, '51
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-30, '51
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
Pharmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Orlando, May, 1951
Public Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
Tuberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Port St. Joe	
Woman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
American Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Atlantic City, June 11-15, '51
A. M. A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Los Angeles, Dec. 4-7, '51
Southern Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loran, Birmingham	Dallas, Texas, Nov. 5-8, '51
Alabama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
Georgia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 4-6, '52
S. E. Hospital Conference	Mr. James E. Crews, Memphis	Mr. R. G. Ramsey, Jr., Memphis	
Southeastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	Augusta, Ga., Mar. 21-22, '52
Southeastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
Southeastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
Gulf Coast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss., October, '51

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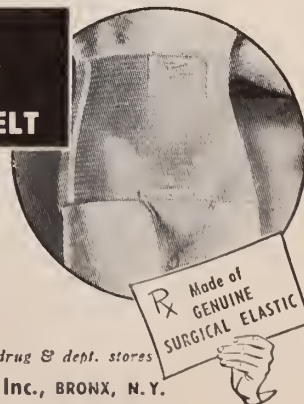
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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	James M. Nixon, M.D. 825 Jenks Ave. Panama City	Harold E. Wager, M.D. Box 984 Panama City		22	19	
	Escambia *Santa Rosa	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	74	65	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	6	5	A-1-52 Arthur J. Butt, M.D. Pensacola
	Jackson-Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	11	
	Walton-Okaloosa	Arthur G. Williams, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	14	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	4	
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	12	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	52	48	
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	7	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	100%	
	Taylor *Dixie-Lafayette	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	223
B	Alachua *Bradford, Gilchrist, Union	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	47	45	
	Duval *Clay	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	245	206	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	24	
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McCane, M.D. Fernandina	Last Friday 8:00 P.M.	10	100%	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
	Putnam	Claude M. Knight, M.D. 121 Madison St. Palatka	James W. Brantley, M.D. Grandin	2nd Tuesday 6:00 P.M.	10	9	
	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	14	
	Brevard	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	20	19	
	Lake *Sumter	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	25	22	
	Orange *Osceola	Fred Mathers, M.D. 314 American Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	147	139	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Thomas F. McDaniel, M.D. 315 Magnolia Ave. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	13	12	
	Volusia *Flagler	Peter A. Drohomier, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	75	67	636
C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	162	148	
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	17	
	Pasco-Hernando- Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	13	12	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	186	177	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	38	
	DeSoto-Hardee- Highlands- Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Stanley K. Wallace, M.D. Schring	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte- Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	25	23	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	85	74	560
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	104	93	
	St. Lucie- Okeechobee- Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	17	13	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	Broward	M. Austin Lovejoy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	75	
	Dade	Jack O. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrieman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	563	424	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	Ralph Herz, M.D. 420 Simonton St. Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	10	8	781

*Supervise and aid until organized separately.

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NOT RENEWABLE AFTER 6 WEEKS.

DATE BORROWED	BORROWER
NOV 20 1953	U.S. Navy, 512th
JAN 5 1953	U.S. Navy, 512th
SEP 22 1953	U.S. Navy, 512th
SEP 16 1957	U.S. Navy, 512th



